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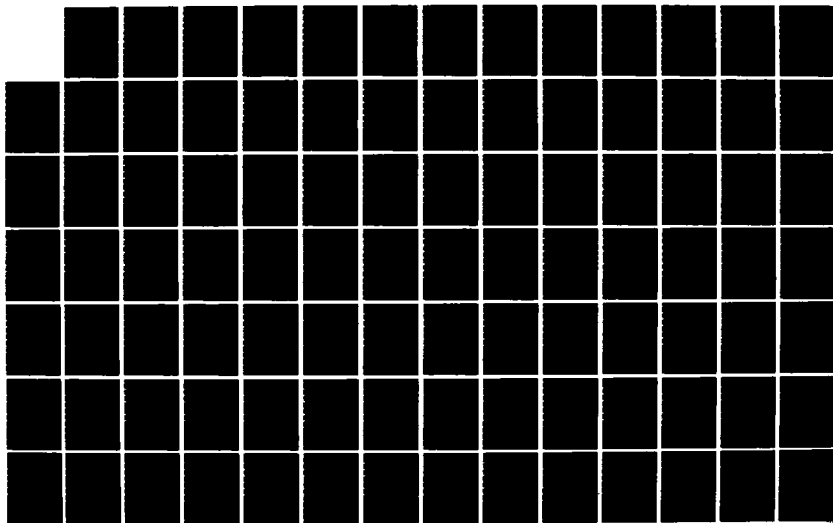
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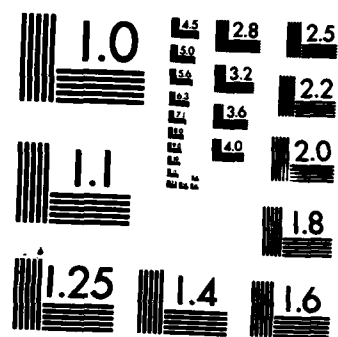
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A CRIMINAL LAWYER LOOKS AT ALCOHOLISM

By

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B.S. in Business Administration - June 1963, Babson Institute

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A Thesis submitted to

The Faculty of

The National Law Center

of The George Washington University in partial satisfaction

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Master of Laws in Law, Psychiatry, and Criminology

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DEDICATION

To Gene P.

A "Gate Keeper" who cares about Alcoholics



Handwritten notes and stamps in the bottom right corner:

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## PREFACE

This paper is written in the sincere hope that my brothers and sisters at the criminal bar, the honorable men and women on the bench before whom we plead our cases, and our valued colleagues in the probation, parole, and corrections professions will be better able to understand the disease of alcoholism, identify the suffering alcoholic, and guide him or her to treatment and assist in his or her recovery.

> The thrust of this paper is to provide a 'how to' practical approach to dealing with the practicing alcoholic in our every day practices, <sup>as criminal lawyers,</sup> As professionals in the legal and related disciplines, we are among the 'Gate Keepers' of society. Through those societal gates, many alcoholics walk each day. Some are in the early stages of the disease; some are in the later stages but still in denial; and some are in the last stages of the disease, suffering from Organic Brain Syndrome, Korsakoff's Syndrome, or advanced cirrhosis. When these alcoholics reach the gates, be they law office doors, holding cells, accused tables, probation offices, or parole offices, an opportunity presents itself for us to become part of the solution to this grave and complicated problem.

The thesis of this paper, then, is to facilitate appropriate management of the alcoholic by the professionals involved in the criminal justice system to the end of best serving the alcoholic, the criminal justice system, and society at large.

PART I  
INTRODUCTION

The story appearing below is an actual autobiographical sketch of an alcoholic who has experienced the criminal justice system directly, repeatedly, and, for the most part, with disastrous results.

Richard's story has never been written before and, to my knowledge, it has been orally related only once previously.

The story is almost entirely in Richard's language. As it was transcribed from a taped interview, the only editorial changes made were to remove my questions from the text, delete some non-focused segments, and to connect Richard's responses with phrases to facilitate a narrative form. I decided against such further editing and word substitution as that might diminish the emotional honesty and directness of the narration.

Richard's story is placed in the introduction partly as an attention-getting device. However, the real value of his story is to let the reader see into the viscera of an alcoholic and perhaps feel some of his emotion in suffering, "reaching bottom," and recovering. Be advised that, as surprising as portions of his story may be, they are true as Richard remembers them.

Here is the frank, unexpurgated, self-told story of an alcoholic who, like so many others, became embroiled in the criminal justice system.

Richard's Story<sup>5</sup>

Well, the drinking started, I had drunk some before I left Baltimore at my mother's and stepfather's, but I really started getting into it, you know, with my father and my stepmother when I was nine. I'd say I was ten or eleven when I really got into drinking



heavy. At that time, I was drinking strictly weekends. It was heavy weekends. Oh, God, a case a night. Just me and a case of beer a night. I remember we used to have drinking contests, and I was the top — I remember one night — I don't remember, they told me, I drank 52 beers in one session, and that was like drinking it and throwing it up at the same time.

As I started drinking, as I said, more and more fights started coming into my life, difficulties in school. I was always in the principal's office. School for me was very difficult. I couldn't seem to concentrate in school. And anyway, I was booted out of junior high school. I think I had two weeks eighth grade education. As I said, I did go — I started junior high school, and that's when really all of my troubles really began, because I started drinking more. I used to go to school drinking. Drinking in the morning before I went to school. In the eighth grade, I would start out with a half a pint in the morning; sometimes, I drank during the day, if I could. It depends if I had money, or whatever, noontime or something like that, we'd get the booze from this guy that stood on the corner — we called them winos at the time — and he'd buy it for us.

Booze was never a problem to get. Not for me, it wasn't. And then, even when we were underage in the State of Maryland, we could just hop over the D.C. line and buy it, you know, nobody asked you for an I.D. or anything. You could go downtown, the bootleggers down there, you know, just pull up and say, "Hey man, what you got?" They tell you, you whip out a few beans, and you've got what you need. And so, anyway, that's when I started getting involved with these friends, so-called friends of mine, started joy-riding, borrowing cars, and fighting. Yeah, this is all where it's really beginning. The emotional part has already been there, it's just building up at this time. You know, I didn't know where my place was in life, and I'm lost. I'm deeply hurt.

Alcohol is — made me whatever I wanted to be. Even in those days it made me — turned me into a — beast, if you want to use those words, oh yeah, macho. One of the rough characters, Mohammed Ali. When I was fighting, I got my licks. Win a few, lose a few, as the old saying goes. I didn't like to admit that. Win a few, lost a few. I been seriously hurt a lot of times. I've been knocked out, unconscious, I've had my knees swollen from being kicked half to death, and, you know, I've been shot at, knifed at.

The reason I was booted out of school was because I was skipping school, getting into trouble, small stuff like that, joy riding is what they call it, borrowing cars, staying out late at night, boozing during weekdays, going to school hung over. Well, just that I didn't care at time whether I went or didn't, or if anybody didn't like it.

During weekdays at this time, I was still pretty much into drinking beer. I would drink during school days, I'd say a 12-pack per day. After getting booted out of school, I didn't have a job, and also I started getting back into the car business, taking people's cars without permission; and then drunk in public. I laid down and passed out right in front of the senior high, right in front of the place, all tanked up, from what, I don't know.

At that time, at that age, I was just mostly drunk in public, and borrowing cars, and also lifting like guns and all from stores, not real guns, but shoplifting toy guns. And then, eventually I got booted out of my father's house, and my father was drinking, too, at this time, so my stepmother told my father that, "Well, I can't tolerate both of you, so one of you has to go." So my father said, "Well," — and this is his exact words and I remember them to this day, he says, — he says, "I'm a little bit older than you, and I think you can handle it out there better than I can, so she's not going to let us both stay here," so out I went into the streets, nowhere to go or anything. I used to sleep in basement apartments and apartment basements, what-have-you. About 14 years old, I was sleeping wherever I could sleep. And whenever the guys — the kids weren't in school, we'd get together and I'd always wind up getting booze, even when I didn't have any money.

As time went on I started getting into more fights, because I wanted to be somebody. I'm talking about really getting into some brawls. How I made it through some of these things without being seriously crippled or killed or something like that! I've been through some violent stuff. Eventually, I got some guns; I had no intentions of harming anyone, I just — the thought of power, and of course that macho thing, too, everybody — certain people knew I had these weapons; it was one of those — in that time, big bad things, you know. "Don't fool with Richard" or "He might blow you away" or something like that.

My father, even though he booted me out of the house, my father and I kept contact. My father and I drank a lot. He used to get pretty tanked up, of course, me right alongside of him.

At 14, I started drinking bourbon, double shots, and next thing I know I'd wake up in the dang car somewhere, didn't know what happened, how I got there. I had blackouts when I was 14.

I'll tell you, back in my earlier years I could drink for a long period of time, and then I would taper off, because I was deeply sick, very sick, physically, and I was just too sick to drink after awhile. Then I'd swear up and down I'd never do it again. Of course it wouldn't be long I'd be right back into it till I'd get sick again. But then it got to the point where as I got older, even though I was sick I just couldn't shake it off. I had to have something to balance my nerves. That started, in the early teens. At times, my father was on and off the booze, too, but when he was drinking vodka I would join him in his early morning nightcap. I'd go on binges and then periods of dryness, and then go back into it, but my binges would last longer. Oh, I could truthfully tell you I don't know how much I was drinking in my binges, because I would drink to pass out. It was constant though. Around the clock. When I would get off it, it would be anywhere between 3, 4, 5 days, but I always made sure I was ready for the weekend.

When drinking, I would get into some outright outrageous terrible fights. I would actually literally try to rip somebody's head off their shoulders. I would try to beat them to death. That was the alcohol in me. All of my trouble has been related to alcohol. I've never been arrested sober. I can tell you that and be honest about it.

Well, let's see. Between ages 15 and 20, there's really not much to tell. All through them years, I'd drink. I'd had jobs, many, many jobs. I could never stay in one place at one time. I was unable to work a lot for the simple reason I was sick. I had construction jobs, electrician jobs, plumbing jobs. I've always had this feeling that I wasn't capable of doing these particular jobs, so I wouldn't hang on to them. In other words, I've always had a low self-esteem of myself, and therefore I never cared for myself much.

Okay, so I'm dating a lot and I've dated some nice ladies in my time, and I would always ruin it through alcohol. Eventually — I guess I got married. I think I was married the first time at 20, 21, something like that. That fell apart. Anyway, alcohol was the main reason for my divorce. She was pregnant before we got married. I got married for that reason. Drinking; finally, it was my staying out, not coming home. Staying out for a day or two, a week, three weeks, two weeks. And she finally decided that it was enough. I let this guy stay with me because he didn't have a place to go for a while. So we started running around and drinking and all that stuff, and him and I got in a big bad fight. I'm talking about a knife fight, and I cut him up pretty bad, so I think that was the straw for her, that's when she — I came home one day and everything was gone, furniture and everything. Only thing, there was a phone laying on the floor, that was all that was there. And I took the blame for it. I was always 100 per cent wrong. Everything that happened was my fault. She didn't know any of my past grievances or anything like that. Sharing was very difficult for me, and I always kept to myself as far as my thoughts, or how I felt about certain things.

Anyway, we were divorced, and it wasn't very long after that that I got married again, and that was a terrible mistake. And that marriage was very brief, too. I had a daughter by my second marriage.

So anyway we had an apartment. I lost it, we had to go stay with her parents for a while. Then a lot of friction started — in a way I liked it and in a way I didn't — because her father drank Jack Daniels and he used to keep a good supply around and I liked it. I lost my job as I lost many, then again, I also got booze anytime I wanted to. Booze was the cause of everything.

Anyway, bad friction became finally with me and her in-laws, and it was just bad — a bad scene there, then it got to where her brother would get involved. So finally that was enough of that, so we separated and eventually divorced.

I was seeing her for a while. I don't mean seeing her as dating, seeing her because I wanted to see my daughter. But all of a sudden she just vanished, disappeared, and then I tried to go through her parents to find out where she was; they wouldn't tell me, and then I was advised to leave well enough alone for my own well-being. And so I did, for a while. And then I went back again and tried to — I was drunk and I wanted to see my daughter. I went in my wife's parent's house, and I knocked on the door, and they opened the door. I banged it in with my foot, and I told them I wanted to know some answers, and "I'll wipe this whole house out," and finally — I don't know how the police got there so fast, but anyway they got there, hauled me out.

Okay, so two divorces are in effect, and they're over with, and so far I keep living. I lost my driver's license, so I started getting picked up for driving without a license, suspended license, and of course I was drinking through all this and getting into more fights, and then I started carrying a pistol around. At this time I was drinking a lot; I was drinking all the time. Around the clock, yeah.

After my second divorce, I became — I guess I was skidrow, because I'd wake up on shopping center parking benches. I'd go into a liquor store when it first opened up, and I would just collapse. I went into DT's. I remember they dragged me into the back of the store so the public wouldn't see me. And the next thing you know the ambulance come and they put the mask on me and all this other stuff. And they'd take me to the hospital. And this happened a long time ago, but I remember this distinctly. This nurse looked down on me, and here I am, sick and all this stuff, and she's looking down at me and she's saying, "So young, early 20's." I remembered that. But they stuck that needle in me to stop me from falling apart. But this isn't the only time this has happened to me. This has happened to me several other times, too; convulsions or DT's whatever.

I was one of these kinds; I just hung around. Eventually, I would get myself established and I'd get myself a place to live and I'd lose it, and I'd go back hanging around the shopping centers. My home was in the woods or in somebody's shed or where I was sleeping. Climb up inside a Goodwill box, or whatever.

I wasn't eating, that's the reason I got into these convulsions, DT's, because it was just drinking. I had no nutrition at all, just alcohol, 100 percent. And at that time I was drinking junk, cheap stuff, cheapest stuff I could buy or get. I was down to wine. Of course, I've drank moonshine.

I'm starting to carry guns. And I got busted for carrying a weapon. That's on my record.

That's not the first time I was ever arrested though. I was arrested and placed on probation. It wasn't hardly no time, maybe a month later, I was back there. I think they put me on probation again for a longer length of time with stricter guidance. Oh, Lord, I was 13, 14 years old. I was — well, joy riding, borrowing cars. I also did do time in the Maryland Training School for Boys, two terms, different. That was for unauthorized use of an automobile. I did, I think, 8 months. I got out. And it wasn't maybe 2, 3 months later, I was back in court again for the same thing. I'll just say it was in my early teens. Okay, I went back to Maryland Training School for Boys, and I escaped from there this time. I couldn't do it for another term. I escaped and eventually I got caught again. And so I was transferred to a forestry camp.

I've been in prison twice. I've been arrested numerous times. The prison terms were for — well — one was store — house breaking. This was the time I was insanely drunk. I had this car, borrowed this car. I ran out of gas. It's funny, it's ironic how I did this, because I had full knowledge of what I was doing but I had that not-caring attitude, I didn't give a hoot.

I had this car, and I drove around and around. I knew where this particular guy was. I drove up in front of this People's

Drug Store and I knew where this guy would be, so I went up there, hot shot, big shot, and he saw me, and I wind down the window. He says, "Hey man, what are you doing?" I said, "Well, I'm riding in this guy's car." He says, "How about it, you and me just messing around?" I said, "Well, you know the car's hot." He gets in anyway. We're going around, we buy booze, started out with whiskey and as the money winds down, we get down to beer, and then the money winds down, we start drinking this wine, whatever we could. This is a matter of hours. So finally, I'm wasted out of my mind. I drive down this particular street. I just parked the car. Well, anyway, there's a straight road, but I parked it, like made a T out of it, and just got out of the car like nothing was happening. I knocked on this person's door and I asked for somebody named Johnson. She says, "Nobody lives here by that name." I pushed my way in the door; I said, "Excuse me, I'm not here to hurt you; I just want your money." So, I didn't see a purse or anything. This guy that was with me said, "There it is." So I grabbed it, and forgot the car, forgot what I was there for, I started running down the sidewalk, throwing stuff out of her purse up in the air, forgot what I even wanted. I run around 2 blocks, I see some other people I knew, they don't know what transpired. So I'm sitting there, leaning against this car, talking like nothing happened. Next thing I know, this big black car came running around the corner and this guy jumps out and whips out this .38 and points it in my face and I just turned ape, and I said, "Man, either we fight or you just shoot." I said, "If you're going to do it, do it, but don't keep pointing that thing at me." Saying worse things than that. Anyway, I'm just saying nasty, profound (profane) stuff to this guy — why that guy didn't shoot me is beyond me, but I remember his face as drunk as I was, and I want to tell you, that man wanted to kill me, and I'm a very lucky man to be able to tell you — sit here telling you about it.

I had two lawyers, state appointed lawyers, I pleaded innocent, I mean, to the end, and they both sat down and told me, when I finally went for my final hearing, court trial, went through a series of preliminary things — and all this stuff, so when the actual time for sentencing came along, or to find out whether I was going in front of a jury or not, they sat down and talked to me and said, "The best thing we can do for you," he said, "If you don't plead to the charges — plead guilty to a lesser charge, the Judge is set on giving you 20 years."

Okay, anyway, when these attorneys told me that this judge was going to give me 20 years, I got pretty scared. So, I agreed to plead guilty to a store housebreaking charge, which at that time — I believe that was in the year, '63, I got two years probation, and I believe I got out — I waited 93 days in jail for that before anything was decided about me. And I got out on my birthday — I don't know how old I was, but I know it was my birthday; it was the 21st of January. So I get out on this probation. It wasn't but a short period and I was in trouble again. I can't remember what that particular crime was. Probably lifting another car, which was a violation of my probation. Okay, first they sentenced me — I did 6 months in the Maryland House of Corrections, Jessop (phonetic) Maryland, and so I figured, well, this is my thinking. They're going to see that I was a model prisoner, and I've already done 6 months, maybe they'll just drop this thing and put me back on probation.

Well, I did that 6 months, went back to court. The same day that my time was up at Jessop, the marshals were there waiting for me. They hauled me back to Marlborough (phonetic) courthouse and gave me 2 more years. They didn't sentence me back to the House of Corrections in Jessop. They put me in the Maryland Correctional Institution in Hagerstown, which I fulfilled for two years. They do give you time off for good behavior, but I never succeeded in doing that because I was very resentful. I got in trouble, got in fights; I didn't respect authority. So, I spent the two years.

I can tell you one time when I got out — I believe it was the Maryland Training School for Boys — and I knew I didn't want to drink. I just knew I didn't. So I got to riding around with some of old so-called buddies, and they were drinking, and we were out, and I told them, "No, I don't want anything to drink." I was drinking Coke. We were just riding and riding and carrying on, and I said after a while, "Give me one beer." And so I drank that beer, and I only remember opening the fourth beer. The next thing I know I'm standing over top this guy, his face all bloody, and my fists are all full of blood, and we're in this gas station. And this guy that I was with, a huge monstrous person, had me over his shoulder to prevent me from beating this guy to death.

It doesn't matter how much you drink or how long you've been away from it, but everything — you never stop. It gets worse, you know.

I did a lot of time; this two years I did; I did a lot of time in what we call solitary confinement, which is a dark room on bread and water. Every third day you get a meal, and the rest they give you bread and water. They put you in a monkey suit and they put you in this room, concrete walls and concrete floors, and you don't know if it's daylight or nighttime, or what time it is or anything. You have a hole in the floor for a toilet. It's just like these drunk tanks they have in the county jail. They may be more sophisticated now, I don't know. I don't plan to go back to find out, I hope.

And I got out of there, I remember it was a beautiful day, the sky was blue. I remember two of the guards took me to the nearest town, Greyhound terminal, and from there I was on my own. They gave me some clothes; I didn't have any clothes of my own or anything.

I was going to do things right, keep my nose clean, and all this stuff; get me a job. It wasn't very long, maybe two days, I was back into the sauce. I was a skidrow bum, getting into trouble, in four to six months, really in the pits. Gradually, people were dropping away from me, and I just didn't have anybody in my life but myself. What I was doing primarily is existing, and I was going to stores and steal baloney and bread and stuff like that. I used to wait for these doughnut men. I used to have these places picked out, and I knew what time they dropped the doughnuts off in the morning, these Giants or Safeways or whatever, and I'd go rip a box off. Then the milkman, I'd wait — I didn't want the milk, but it was just something to wash it down with.

I have to say I felt what people were feeling for me, which was — let's face it; he's a worthless son-of-a-bitch. You know, he doesn't hold a job. He's blown two marriages, you know.

Well, I'm doing nothing but just hanging around shopping centers, waking up on park benches, going into liquor stores and falling apart, stuff like that. I told you this happened on more than one occasion. Just basically existing, hanging around, sleeping in woods.

I left Maryland and I guess I was 28 when I came to the state of Virginia. When I left Maryland, I left Maryland and everybody in it. I always blamed Maryland for my problems anyway, because Maryland — Baltimore, Maryland, Prince Georges County — people just didn't understand.

By the way, all through these violent stages, there were a couple of people in particular always thought I was crazy, that I needed a psychiatrist. Never mentioned that I had an alcohol problem, and I took high resentment to that; the idea that I needed a psychiatrist; blow steam ... telling me that I was crazy ... blow steam.

I continued getting arrested for small stuff. Never went to prison after 1966. I continued making a lot of local jails, getting busted and thrown in jail for maybe 30 days, 60 days for drunk in public. I think I got busted for vagrancy once. I was never arrested where alcohol was not involved. I was never arrested sober. I can honestly say that. When they threw the handcuffs on me, I was loaded. I'm getting arrested for just being a total nuisance and fighting now. Eventually, I wasn't getting much in fights, and I was drinking and being a public nuisance. For instance, I would get in fights right in the middle of the drugstore. I remember a particular incident when all of a sudden, I just went beserk, and this guy started running in the drugstore and we started going at it in there, and we started knocking things off the shelf and everything. I was drunk at the time. And this guy just came home; he was an Army man. He was just minding his own business, and boy, I've done some stupid stuff in my life. But you know, everytime I've done something stupid, I have this guilt feeling, and I had to drink to let go of it, instead of doing something about it.

And going back a few years, when I realized — I realized years ago alcohol was a problem. I just didn't know what to do about it.

I was in Virginia, and I started getting arrested for fights, and I've got a rap sheet now about that long; just fights and being a plain drunk, you know, stuff like that. So that tells me at that time, the state of Maryland wasn't the cause of my problems.

So anyway, I kind of buckled down after — maybe things started slowing — I'm still into my drinking, but not getting into jail and stuff; maybe around 30, 32 years old, something like that. I've been pretty clean the past four or five years. I think the reason I was not getting arrested was because more — as I said, I came over to Virginia and I didn't know anybody, and I was very much to myself.

I worked my first job in Virginia; I worked for the county. I blew that job through drinking, then I took another job as a porter, and now I'm in a job ever since that job, and this is the longest job I've ever had in my life.

I was doing a lot of dating, messing around women, and getting into barroom brawls, but that slacked off after a period of time. I don't know why, and I got more and more to myself, and eventually, that was all it was, just me and the world. And, I didn't know from

one minute to the other which way I was heading. I knew I was in trouble, but I didn't know how to get out of it. I don't mean just with the law; I mean with myself, and I knew my thinking was wrong, the kind of thinking I was doing.

I had been introduced to AA (Alcoholics Anonymous) in 1968, but I completely forgot about it. I went to a meeting with my father. I think the court somewhere encouraged me to go, or the probation officer. It was during probation, and also I did go once or twice with my father; I remember that very well. It was a speaker's meeting, I remember that, and at that time nothing registered to me. I didn't want to be there. I just didn't want to be there, I wasn't interested, and — and then I was out for a period of years. I completely forgot about the AA program.

Anyway, in 1977 — I'm getting a little ahead of myself here, but that's all I can think of right offhand — I was dating this gal, and as I said I got away from the violence and all that for a little bit, but I was dating this gal and we were living together — she's the type of woman that could really humiliate you — and I tolerated a lot of it. One time I stopped drinking for her. That's why we got together. She asked me if I'd give up the booze. I did slowly but surely, and I went through a helluva withdrawal doing it all by myself. I didn't have the AA program or nothing. Anyway, many sleepless nights.

So anyway, I eventually came off of it. Then things got bad between her and I and I started drinking, picking it up more and more — increasingly more and more and more — and then one night I came home terribly drunk, and she said the wrong things to me, so I knocked her around. She degraded me. She — I can't — words that just shouldn't have been used, it was just low class, in other words. Scum — and all that stuff. "Disgrace," that's the word she used. And it just blew my mind, and I just — and that's how I got into the Program — believe it or not. How I thought of AA; I knew there and then that was it for me.

I cracked her nose and blacked her eye, the bridge of her nose. And I was still drinking, and I went for help. Why help came into my mind at that time, I don't know. I went to this person here in Arlington. I couldn't even remember my phone number, and I've had this phone number quite awhile, and I've thought it many, many times and I'm trying to give this guy my phone number and he's trying to call this gal and to find out the nature of the problem and trying to get this straightened out, and I just couldn't remember my phone number.

So — of course, he realized then I was in trouble. So he recommended me to go through some program. He recommended the Fairfax Detoxification Center.

She had a brother, which I didn't know this till later, that went through Arlington, or whatever they have there, the clinical group, the ATU.<sup>6</sup> And so we arranged it where I would go through there, and that was a job talking my boss into letting me do that also, because he didn't quite understand. But he went with it, so I went through the program and it was a good program, but I drank after I got out of there, because I didn't know what to do with



myself. I was too lost. All I knew was drinking in bars. Going to work, drinking in bars, going in and getting my brew, go into bars. That's all I knew. I didn't know what to do with myself. I was lost.

So I drank, and I only drank for a day and a half, and I got back, I called my sponsor, her sponsor in the AA program. Told him what had happened. And he asked me what was I thinking of at the time, and —. I was just lost. I didn't know what to do with myself, you know. I didn't know —. I mean, I've been drinking for all these years, and all of a sudden I'm coming out of this hospital — I guess frightened. It was reality slapping me in the face. And I didn't have nothing in my body to cope with it.

Well, anyway, it was a struggle for me, I didn't want to stay in the AA program, but I did, and I struggled through it, and sharing stuff is difficult for me, and it always has been. I didn't want to share my life with anybody for I didn't think it was worth it, where I was worth anybody or anybody wanting to be interested in me.

My first year in the Program was pretty rough, and —. But, I've been in the Program since, three years and 5 months, something like that. What I'm doing now, I feel that I'm getting out of myself more, and I'm sharing a little bit more, not as much, or not much, but I am a little more than I have been. People know things about me now, where I come from, and I still haven't completely let go of the past; the past still bothers me. Things I had done, things that I thought people had done to me, that sort of thing, still needles me a lot. I could tell you where, when I was drinking, there was a series of times where I could have been involved in situations such as armed robbery; I've had thoughts of murder in my heart as well. I'm very lucky I didn't commit some of those offenses.

After treatment at Arlington, I went to a lot of meetings (AA), heavy, when I first got out of there, and as I said, I did drink about a month after I got out, but it was only for a day and a half. I was very fortunate, and I doubled my meetings. I went to meetings and meetings. Even if I didn't want to go, I went anyway. Weather didn't stop me; nothing stopped me. I went and I made sure I got there because I knew I should be there.

I don't go to as many meetings now as I used to, but I know where I can go. I pick up the phone when I don't go. AA enabled me to talk about myself some. I'm not as strong into it like others, but I'm able to open up. I've met friends. It gives me — it makes me do soul searching. It's made me or taught me to do some searching of myself, and you know, it's a lot of things, and also since I've been sober, a lot of these things that I had done has set into my mind also, and kind of made me feel really guilty there, but it teaches me the fact that I was sick, and I've got to let go of this thing. I was not in my right mind, and I was under a disease at the time. I don't have to — it teaches you that I won't forget or I can't dwell on it, the bad things that happened to me.

Now, I haven't quite succeeded in that, but I'm not drinking. I wish I could be more open than I am, but gradually, I think there has been progress, a lot. Also, the program teaches you to reach out to others as others have reached out to you. That's what it's

all about; unity. Staying together, working together; we're all here for the same reason. We got different stories, but we're there for the same common thing -- Alcoholism.

In all the time I was in jail, and other undertakings, I never got any direction or therapy for my alcoholism. The only reference to AA I received was from my probation officer, once, when he said, "I want you to go to AA meetings, and I want you to not drink." I think I was directed to go to two meetings a week at that time. Of course, I didn't want to go. I think I needed the intensive treatment at Arlington ATU, as well as AA, although I drank for a short period after I received it. I needed that education. Definitely, that's a major factor for me being here today, for me. I've dried out before.

Oh, if I'd had some sort of training, or treatment, while I was in jail or prison, most definitely, it would have helped. There weren't even any AA meetings in the jails that I was in. I think it would be an awfully good idea to have treatment facilities in jail because most of them are in there as a result of alcohol. Mostly everybody I associated with in the jails and prisons was an alcoholic. I would say 80% of the total population of the jails and prisons I've been in were alcoholics.

My only reason for telling my story is if someone can benefit from this, relate to this, that it would be useful to them. That's all to me. I don't have personal gain out of this. This is my way of sharing. As I said, I'm not a sharing person, but I do share in my own way, differently from others, but this is one of my -- if you want to call it -- contributions. And I'm glad I'm doing it.

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Although Richard's story focuses on his disease and his consequent defective and often criminal behavior, it is replete with examples of our perceptive difficulties and inadequate understanding of Alcoholism. We "gatekeepers of society," the operative personnel of the criminal justice system, were ineffective when we were confronted with this sick individual. If someone, early in Richard's life, had realized his root problem, he and society might have been spared much pain, trouble, and disagreeable experience. In all his contact with the criminal justice system, from the boys' homes through his prison experiences, only one probation officer ever saw his alcoholism or cared enough to try to get him help for this problem. I submit that the failure of the system to deal effectively with Richard's disease is indicative of a societal problem of substantial dimensions.

This problem can be corrected through confronting the disease of Alcoholism, learning the nature of the disease, how to recognize it, and what to do for the person in whom the disease is present.

## PART II DEFINING THE DISEASE

### The Problem

The disease of Alcoholism is one of the most pervasive problems mankind has ever experienced. It has existed in all societies, throughout all of history, and continues to this day. It has been classified as a curse,<sup>9</sup> a mental defect,<sup>10</sup> a moral defect,<sup>11</sup> a condition,<sup>12</sup> and, finally, as a disease.<sup>13</sup> The ancient and modern literature of the civilized world is replete with references to drunkards and drunkenness.<sup>14</sup> Yet, our understanding of the disease is so rudimentary that if mankind tried its utmost to avoid learning about the disease, we could hardly know less than we do today. Of course, that is precisely what we civilized men have done; tried our best to avoid learning about the disease. Most of us don't even feel comfortable talking about its existence. "Isn't it too bad Joe has heart disease?" "Isn't Mary brave, dealing with her cancer?" But, you rarely hear, "Isn't it too bad that John suffers from alcoholism?" When his acquaintances finally have enough of his behavior, they might call John a "G... D... Drunk," but rarely do they mention "Alcoholism." Alcoholism takes a lower rung on society's shame ladder than do "social diseases." If someone contracted syphilis or gonorrhea, there would be little doubt as to how he or she became infected. However, how Joe contracted alcoholism is still a mystery.

Later in this section, I will describe the "denial syndrome," as it applies to the alcoholic. It is interesting to note that "denial" is not only an internal manifestation of alcoholics; it is also society's method of dealing with the disease. Society's avoidance of the disease of Alcoholism is nothing more than "denial" on a macro-scale. Society may be able to play this denial game with some impunity for a limited period of time, but we in the legal and related fields cannot ignore the disease.

If we play the denial game, people die! In an article titled Alcohol: The Violent Connection,<sup>15</sup> Dr. Joseph Zuska, the director of the Alcoholism Treatment Unit at St. Joseph's hospital in Orange County, California, and co-originator of the Navy's Alcohol Treatment Program at Long Beach, California, collects some telling statistics regarding alcohol involvement and crime.

A quick perusal ... points to alcohol as playing a large part in:

- 64% of Homicide
- 72% of Stabbings
- 69% of Beatings
- 55% of Shootings
- 67% of Sexually Aggressive Acts Against Children ...<sup>16</sup>

He goes on to point out that in contrast to the alcoholic's violent acts, the heroin addict commits crimes largely against property.<sup>17</sup>

Although these figures refer to alcohol-related crimes, not alcoholism-related crimes, the nature of the disease is such that there may be no meaningful difference. Since the individuals got into serious trouble while under the influence of alcohol, most of them can be diagnosed as having the disease under several of the better definitions. A more complete discussion of the diagnostic criteria follows.

A significant national study reports that the use or abuse of alcohol was involved in ... "Half of all traffic fatalities and one-third of all traffic injuries .. more than one-third of all suicides ...."<sup>18</sup>

Mr. Lee Estep, Esquire, an eminent San Diego, California, attorney, with vast experience in the trial of criminal cases and possessed of an in-depth knowledge of the disease says, "Out of the murder cases I tried and defended ... in each one of them, there was Alcoholism."<sup>19</sup>

In my own experience; trial of over 200 cases, arguing appeals in approximately 100 cases, and review of over 2000 cases; I have seen definitive alcoholism in more than 50% of the cases.<sup>20</sup>

When the devastating effects of alcoholism on society are considered, the criminal acts committed, the mental and physical abuse suffered by relatives and friends of the alcoholic, and the physical, mental, and emotional damage suffered by the alcoholic himself, the importance of this huge problem starts to come into focus.

It engulfs all whose lives touch the sufferer's.  
It brings misunderstanding, fierce resentment,  
financial insecurity, disgusted friends and  
employers, ...<sup>21</sup>

The suffering alcoholic himself either ends up dead from the direct or indirect effects of his disease, insane, incarcerated, or, in recovery with abstention and a formal or informal treatment program.<sup>22</sup>

Alcoholism is indeed a massive problem for all of society.

#### Alcohol Use v. Alcoholism

Everyone who takes a drink is not an alcoholic, nor does the usual drinker become one.

Alcoholic beverages are pleasant, usually harmless, social lubricants which, for the normal drinker, provide recreation and enjoyment. Nine out of ten drinkers drink their whole lives with no real problems.<sup>23</sup> They might get "tipsy" once or twice a year, but they let someone else drive home, they sleep it off that night, and are none the worse for wear the next day.

However, about 10% of the drinkers of alcoholic beverages, at some time during their drinking years, develop the disease of alcoholism. This is the group that is the focus of this paper.

The normal drinker gives thanks for ... "Wine that maketh glad the heart of man."<sup>24</sup> For the alcoholic, that same "wine" is poison.

#### Alcoholism - Some Definitional Attempts

In attempting to objectively define the disease, I will present a variety of definitions propounded by members of various disciplines. By analyzing and comparing these definitions, culling the worthy portions from the less worthy portions, an understanding of the disease and the societal setting can be developed by the reader.

<sup>25</sup>  
Dr. Gene Purvis, M.D., psychiatrist and former director of the Alcoholic Rehabilitation Service, U.S. Naval Regional Medical Center, San Diego, describes the difficulties in defining alcoholism this way:

The definitions of alcoholism are legion. It really depends upon one's training and one's discipline how alcoholism is defined. The physician, internist, would define alcoholism as a physical disease process, until he's enlightened and taught the disease and its many manifestations. The psychologist would define alcoholism as an interruption of the learning process or an intellectual disease, and would test for variations in intellectual functioning in different stages of this disease process.

Psychiatrists would focus on the emotional part of the disease; alcoholism adversely affects the emotional environment of a person's life.

The minister, or man of the cloth, would focus on the spiritual bankruptcy of this disease process. The sociologist would focus upon the social aspects of the disease process. The family and child counselor would focus on the family aspect of the disease process. The lawyer would focus and define it in terms of legal problems caused by the drinking and the wild behavior; so one's discipline would influence one's definition of this disease process. When that happens, one ends up with an unmanageable definition of the disease. It becomes so complicated that it loses meaning and loses the pragmatic effect of getting the alcoholic's attention, because he can only say, "I don't have that part yet." So the simple definition of this disease process is what most people who are knowledgeable about this disease use.

A simple definition of alcoholism is required if something is going to be done with it. A lengthy, complex definition of alcoholism that includes all facets is merely an academic, intellectual exercise that does not contribute to solving the problem. It becomes the problem.<sup>26</sup>

There are many accepted definitions of the disease and, as Dr. Purvis points out, each one identifies its author's discipline.

Since this paper is written by a lawyer and for people of the legal and correction professions, I will attempt to derive a definition usable by lawyers, but which borrows from the literature of all the interested professional fields. Most importantly, as Dr. Purvis enjoins, the definition I derive must be short and simple.

#### The Medical View

Medical definitions of the disease of alcoholism are numerous. However, diverse and complicated they may be, we are indebted to the physicians for the characterization of alcoholism as a disease. Dr. Purvis says:

I have dealt with this problem of a definition since I began my interest in the disease of Alcoholism. I say the "disease" of Alcoholism; because, as a physician, it is easier for me to conceptualize this process as a disease. It fits every category or criteria of the definition of a disease that I know, and therefore, I accept Alcoholism as a disease.<sup>27</sup>



When the American Medical Association (AMA) accepted the fact that alcoholism was a disease, it published the following definition in a small, informal book on Alcoholism.

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead, usually, to intoxication if drinking is begun; by chronicity; by progression; and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupation, and/or social adjustments as a direct consequence of persistent and excessive use of alcohol.<sup>28</sup>

In 1976, the following complex definition was adopted by the National Council on Alcoholism:

#### Definition of Alcoholism

ALCOHOLISM is a chronic, progressive, and potentially fatal disease. It is characterized by tolerance and physical dependency or pathologic organ changes, or both—all the direct or indirect consequences of the alcohol ingested.

1. "Chronic and progressive" means that the physical, emotional, and social changes that develop are cumulative and progress as drinking continues.
2. "Tolerance" means brain adaptation to the presence of high concentrations of alcohol.
3. "Physical dependency" means that withdrawal symptoms occur from decreasing or ceasing consumption of alcohol.
4. The person with alcoholism cannot consistently predict on any drinking occasion the duration of the episode or the quantity that will be consumed.
5. Pathologic organ changes can be found in almost any organ, but most often involve the liver, brain, peripheral nervous system, and the gastrointestinal tract.
6. The drinking pattern is generally continuous but may be intermittent, with periods of abstinence between drinking episodes.
7. The social, emotional, and behavioral symptoms and consequences of alcoholism

result from the effect of alcohol on the function of the brain. The degree to which these symptoms and signs are considered deviant will depend upon the cultural forms of the society or group in which the person lives.<sup>29</sup>

When the real quest is for general understanding of the disease, this more complex definition is not helpful.

The American Psychiatric Association tended to obfuscate the problem in its definitional attempt published in the Diagnostic and Statistical Manual II.

1. American Psychiatric Association

DSM - II

III Neurosis

#303. Alcoholism. This category is for patients whose alcohol intake is great enough to damage their physical health, or their personal or social functioning, or when it has become a prerequisite to normal function. If the alcoholism is due to another mental disorder, both diagnoses should be made. Types:

303.0 episodic excessive drinking

303.1 habitual excessive drinking

303.2 alcohol addiction

303.9 other and "unspecified" alcoholism.<sup>30</sup>

After repeated readings of this definition and analyzing the category under which it appears (Neurosis), I am not sure that the APA really did accept alcoholism as a disease. It is unclear from the language. In 1980, in "A Psychiatric Glossary," the APA did much to clarify its position and provide a more helpful definition.

"Alcoholism - A chronic illness manifested by repeated drinking that produces injury to one's health or to social or economic functioning."<sup>31</sup>

The World Health Organization (WHO), in 1977, defined alcoholism:

2. International Classification of Diseases, WHO, 1977

Alcohol Dependency Syndrome

A state, psychic and usually also physical, resulting from taking alcohol, characterized by behavioral and other responses that always include a compulsion to take alcohol on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence; tolerance may or may not be present.<sup>32</sup>

Although it appears that the WHO tacitly recognizes that alcoholism is a disease, this definition indicates the kind of avoidance and denial discussed earlier.

In "Alcoholism: A Treatable Disease", published by the Johnson Institute, no actual definition is given. However, a series of five characteristics of the disease are presented.

1. The illness can be described.
2. The course of the illness is predictable and progressive.
3. The disease is primary - that is, it is not just a symptom of some other underlying disorder.
4. It is permanent.
5. It is terminal - if left untreated, it inevitably results in premature death.<sup>33</sup>

This simple description by parameters is more helpful than many longer, more complicated, conceptualizing attempts.

Dr. Joseph Zuska,<sup>34</sup> in a personal interview, cut through the medical, definitional, obfuscation with éclat when he described a seminar he had attended, the goal of which was to refine a definition of Alcoholism. One of the attendees, who was an alcoholism counselor,

presumably not a physician, said, "I've never heard so much c... in all my life! Alcoholism is an upward manifestation of a deep underlying drinking problem."<sup>35</sup>

In light of the trend toward pomposity patent in some of the other definitional attempts, this humorous, direct approach, seems like a breath of fresh air. In a serious note at the interview, Dr. Zuska presented an extremely short and cogent definition.

"... alcoholism is drinking that causes either dependence or harm ..."<sup>36</sup>

He further explains,

"If there's dependence or harm in the drinking, that's what it is [i.e., Alcoholism]. It doesn't have to be any kind of drinking in the morning or two quarts a day or anything like that. It's not the quantity that does it, it's what it does to the individual."<sup>37</sup>

<sup>38</sup>  
Dr. Purvis is in substantial agreement with Dr. Zuska, and quotes him in saying, "anything that causes a problem is a problem." Dr. Purvis then goes further and presents the most cogent description and exposition of the disease of alcoholism I have found within the medical sources.

"A person has alcoholism if they cannot consistently decide if they're going to drink or not, and if they do decide to drink, they cannot consistently decide if they're going to stop or not."

I have never met a normal drinker or a social drinker who has stopped drinking, therefore the person that stops drinking has at some level of awareness recognized the problem and is trying to solve it by avoiding, . . . , the cause of the problem, which is the alcohol.

I've heard this definition of alcoholism, . . . [it] is not mine. It is described as a chronic, progressive, relapsing, life-threatening disease that is one hundred percent fatal if untreated, and is one

hundred percent treatable. Now, that one hundred percent treatable does not imply that it is one hundred percent successful in the treatment, because the treatment process for the disease of alcoholism requires at least a partial or modicum of cooperation and interest from the patient who has the disease.

So alcoholism is a chronic, progressive, relapsing, life-threatening disease process. It is important to the patient to know that he has it. If it's a treatable disease process, then there is hope. Alcoholism is not like a terminal or inoperable or untreatable cancer. It is a treatable disease."<sup>39</sup>

#### The Social Science View

The social, scientific, and other non-medical theoreticians are no less susceptible to the tendency to obfuscate the definition of the disease of alcoholism than are the healing practitioners.

Characteristic of this tendency is this definitional attempt by a national committee of social scientists who met in Salinas, California, when they attempted to give the definition a sociological flare:

#### DEFINITION OF ALCOHOLISM FROM THE COMMUNITY MODEL VIEWPOINT

Alcoholism is an illness or condition which is a reciprocal relationship between the individual and his social environment. The condition is characterized in the individual by the developing dependency on alcohol resulting in alienation, dependency, loss of self-esteem, role dysfunction and an apparent irreversible inability to safely ingest alcohol. The condition is characterized in the community by responses and practices which actively create social pressure to drink and which reinforce individual alienation and dependency. The condition is further characterized by denial of the problem by the individual and/or the community, unless and until visible dysfunction results in recognition.<sup>40</sup>

Although the rhetoric does violence to Dr. Purvis' clarity theory, the denial syndrome is mentioned, and that is most important when attempting to understand the disease. In-depth discussion of denial will follow in this section.

Wallgren and Barry, in their work, Actions of Alcohol, synthesize several definitions of the disease and note that three criteria are generally present before a person is considered an alcoholic.

- (a) Large quantity of alcohol consumed over a period of years.
- (b) Abnormal, chronic loss of control over drinking, shown by inability to refrain or inability to stop.
- (c) The drinking causes chronic damage to physical health or social standing.<sup>41</sup>

Although this article is helpful and well written, the authors fall into the trap of attempting to look for differences between alcoholics rather than similarities. This may be a result of their heavy reliance on Jellinek's work, distinguishing five categories of alcoholics.<sup>42</sup> They eventually derive a theory that alcoholism should not be described as a simple disease, although it should be treated medically. This multi-category emphasis is contrary to the more modern and better medical views and makes treatment of the disease very much more difficult.<sup>43</sup>

In A Dictionary of Words about Alcohol, published by the Rutgers Center of Alcohol Studies, alcoholism is defined in true sociological open-ended terms.

alcoholism [from NL alcoholismus, invented by Magnus Huss, 1849] A chronic and usually progressive disease, or a symptom of an underlying psychological or physical disorder, characterized by dependence on alcohol (manifested by loss of control over drinking) for relief from psychological or physical distress or for gratification from alcohol intoxication itself, and by a consumption of alcoholic beverages sufficiently great and

consistent to cause physical or mental or social or economic disability. Or, a learned (or conditioned) dependence on alcohol which irresistibly activates resort to alcohol whenever a critical internal or environmental stimulus occurs. Or, (alcohol) addiction (q.v.).<sup>44</sup>

According to the definition, is alcoholism a disease or a symptom of an underlying psychological disorder?

This kind of free-form definition, inclusive as it may be, is unmanageable and unhelpful to anyone trying to learn about the disease. Such exercises in vagueness are primary, direct, evidence of societal avoidance (denial).

In the First Special Report to the U.S. Congress on Alcohol and Health (1971), alcoholism was defined as follows:

ALCOHOLISM -- A chronic behavioral disorder which is manifested by undue preoccupation with alcohol to the detriment of physical and mental health, by a loss of control when drinking has begun (although it may not be carried to the point of intoxication) and by a self-destructive attitude in dealing with personal relationships and life situations. Although there is no strict dividing line between alcohol abuse and alcoholism, when a person develops increased adaptation to the effect of alcohol, so that he needs increasing doses to achieve and sustain a desired effect, and shows specific signs and symptoms of withdrawal upon suddenly stopping drinking, this is considered alcohol dependence or addiction.<sup>45</sup>

The lack of reference to "disease" is of interest in this definition. It describes the disease by symptoms, but classifies it as a chronic behavioral disorder. This approach is most unfortunate. Acceptance of such a classification by an alcoholic could have adverse effects on his recovery process. He conceptualizes himself as having a "behavior-disorder," rather than a disease. The disease concept facilitates a healthy, emotional, self-image, while the term "behavior disorder" alludes to moral judgement and a "bad person" image. This negative self-image can spell disaster.

A much more enlightened and therepeutic definitional approach has been taken by the U.S. Navy. The Navy has been a societal vanguard in the treatment of alcoholism and has accepted the disease concept completely. The Navy's definition of alcoholism is a model of brevity if not completeness. However, as Dr. Purvis says, "clarity and brevity are the most important criteria."<sup>46</sup>

Alcoholism. A nonratable disease characterized by psychological and/or physical dependency on alcohol.<sup>47</sup>

In the official directive, implementing the Navy's policy on alcoholics among Navy personnel, "alcoholism" is dealt with in equally clear and concise phrasing.

Alcoholism is an illness for treatment and rehabilitation purposes.<sup>48</sup>

Generally, the social scientist's view toward defining alcoholism is overcomplicated, confusing, and sometimes destructive when the disease concept is ignored. However, the consideration given to the concept of denial is very helpful.

Certainly, in deriving a final working definition, valuable input can be taken from both the medical and social approaches.

#### The Denial Syndrome

The disease of alcoholism is characterized by an almost unique symptom or mechanism known as denial. In very simple terms, if a person has alcoholism, he will deny he has alcoholism or that alcohol is interfering in his life. As the disease progresses, the alcoholic will become more and more vehement in his denial. As he or she drinks more and more, he or she admits to drinking less and less, and denies alcohol involvement in his or her life problems, until the final breakdown of



the denial symptom and the beginning of recovery, if that takes place. Many alcoholics deny themselves into the grave.

This denial mechanism does not exist in most other disease processes. People with heart disease do not generally deny their disease, nor do cancer patients. Then, because denial is a primary characteristic of alcoholism (and probably other chemical dependencies), the alcoholic denies the very thing that is killing him, making diagnosis and treatment most difficult. A diagnosis of the disease is sometimes made on the basis of heavy use plus denial.

Dr. Purvis explains the denial component of alcoholism as follows:

Alcoholism is a process where the person that has it, without being consciously aware, denies the problem. The primary mechanisms of defense in this process are denial, rejection, rationalization, and intellectualization, so that we end up with a person who's having all kinds of problems in their life, absolutely related — causally related by the chemical, ethyl alcohol, and they cannot . . . I do not say, "will not" — cannot see it, because of their unconscious ego-mechanisms, the defense that prevents them from recognizing the problem.<sup>49</sup>

Denial is a pervasive mechanism in alcoholism: It not only dominates the rational and emotional responses of the alcoholic, it also invades the lives of "others" in the alcoholic's life; significant and otherwise. Dr. Purvis explains this syndrome this way:

So the denial of the disease goes both ways. The alcoholic personally denies it, so he can maintain his drinking, and the people who are . . . [around] him or live with him deny it because they don't want to interfere in something that they don't know how to handle. The status quo remains preferable to a life change if we don't feel that we'll be able to live with the life change. Most people who have lived around

alcoholism are seeking some sort of predictability, because their life has been unpredictable, and they participate in the denial and the rationalization and the projection, as well as watching the alcoholic participate ...

So alcoholism is a process, a disease, where the person that has it becomes the last one to know that he has it, and the people around him are hesitant to tell him he has it, because they don't know what to do about it, including the doctor who doesn't make the diagnosis of alcoholism, because he doesn't know how to treat it. He doesn't make the diagnosis of alcoholism because of social stigma with that diagnosis, [even though that is] decreasing now, and wants to protect his patient from "harm." And while he's protecting his patient from this "harm," from society, he is participating in killing his patient by covering up the disease process of alcoholism.<sup>50</sup>

In Alcoholism, a Merry-Go-Round Named Denial, the Reverend Joseph Kellermann, former Director of the Charlotte, North Carolina Counsel on Alcoholism, presents the denial mechanism in play form. He traces the denial in the alcoholic in Act I, then in Act II, he presents and analyzes the other players in the play. The Enabler is described as a very destructive player who, in an effort to save the alcoholic from some impending disaster, covers for him, lies for him, and interferes with his learning from or experiencing the natural consequences of his acts; thus prolonging his period of denial and eventual recovery. This role can be played by a wife, a good friend, or a professional. The Reverend Kellermann accurately portrays the professional Enabler thusly:

Professionally, this role is played by ministers, doctors, lawyers and social workers; members of the "helping professions." As most professional persons today have had not one single hour of scientific instruction on alcohol and alcoholism, they act in the same manner and for the same reason as nonprofessional Enablers.<sup>51</sup>

In The Enabler: The Companion to Chemical Dependency, an excellent publication by the Johnson Institute, the enabler is explained, at least at first, as an unwilling victim of the alcoholic's denial, responding to the alcoholic's aberrant behavior by either "excusing the behavior because it is seen as "normal" or "excusing the behavior because it is seen as the result of another problem"

As the disease progresses, the enabler avoids the disease by any method possible. When that becomes impossible and the light begins to dawn as to the presence of alcoholism, the enabler starts feeling guilty, that the alcoholism is somehow the enabler's fault. Finally, the enabler tries to control the alcoholic's drinking, taking over the alcoholic's jobs, lying for the alcoholic; generally trying to save him while actually doing him harm.<sup>52</sup>

Enablers are playing the denial game. They kill the alcoholic with kindness, when he really needs "tough love"<sup>53</sup> and to be held responsible for his action.

Recovery programs for both the alcoholic and the enabler will be discussed in a later section of this paper. The denial/enabler syndrome is a large part of the concept that alcoholism is a family disease. The theory is that to adapt to the unreasonable behavior, denial, and brutality of the practicing alcoholic, the people who choose to stay with him or her become ill as well. A normal, healthy person would refuse to take part in the sick, emotional games that the alcoholic plays with his significant others. The recovery process is, therefore, often necessary for the family of the alcoholic, as well as the alcoholic.

We lawyers and related professionals must always keep in mind the denial mechanism when dealing with someone we suspect of being an alcoholic. We all know that most clients tend to shade a story to their

best interests. However, a practicing alcoholic will be in denial and may tell absolute falsehoods which he may actually believe. The rule of thumb when questioning an active alcoholic is: Presume he is not telling the truth because he probably does not know the truth himself.

#### The Legal View

The legal profession has not forged any great breakthroughs in meaningfully defining Alcoholism. It has in fact been a receptor of other definitions, usually borrowed from the medical profession. This is not by way of criticism, since defining a disease is not a legal function. We, in the law, have a compulsion for precision in the use of language. This quest for precision has occasionally brought us under the critical eye of other professions because, by our legal methodology, we tend to narrow the somewhat fuzzy definitions created by the other disciplines.

Commander Jerry Bunn, USN,<sup>54</sup> the Director of the Naval Alcoholic Rehabilitation Center, in San Diego, gives vent to this complaint:

"You know, the issue often gets around, ... [to] such a stupid thing as — well, he's not an alcoholic, therefore, he hasn't got a problem. G... D..., if he got arrested and alcohol played a role in it, he's got a problem. And we keep waiting for this magic thing called alcoholism to appear before anything's done. And what's happened, we've pushed and pushed the definition alcoholism ...

... There's a lot of people out there getting DWIs more than one time that are not alcoholics in today's definitions, because, like I say, they are more narrowly defined."<sup>55</sup>

As lawyers, and professionals in legally related fields, we should be aware of our inclination toward precision and, for the therapeutic good of our client, resist the tendency to restrict our working definitions.

Alcoholism is poorly defined in the Attorney Dictionary of Medicine and Word Finder:

alcoholism (al'ko-hol-izm). 1. The morbid condition resulting from a prolonged intake of alcohol, especially in excessive amounts. The pathologic changes affect the liver, the digestive system, the nerves, etc. 2. The condition of being addicted to alcohol. 3. Poisoning by an excess of alcohol.<sup>56</sup>

Although this dictionary was published in 1978, the terms "disease" or "illness" are amazingly missing from the definition of Alcoholism. Fortunately, this manifest denial is not pervasive throughout the legal community. Since Powel v. Texas<sup>57</sup> was decided in 1968, and the Uniform Alcoholism and Intoxication Treatment Act<sup>58</sup> has been progressively adopted by more and more states, at least titular acceptance of the disease concept of Alcoholism is becoming more pervasive within the legal discipline. Among the cases discussing the disease concept are: Flinchum v. Commonwealth of Virginia;<sup>59</sup> Easter v. District of Columbia;<sup>60</sup> Matter of S.D., Jr., et. al.;<sup>61</sup> Gorham v. United States;<sup>62</sup> Mathews v. Buycrus-Erie;<sup>63</sup> State of Washington v. Kent;<sup>64</sup> State of Washington v. Heath.<sup>65</sup>

Although there is reasonably wide acceptance of the disease concept throughout the law, examples of misunderstanding the disease are prevelant. In Attorney Grievance Committee of Maryland v. Burka,<sup>66</sup> the court in discussing other analgous cases, held, "dishonesty substantially resulted from mental illness, in each case stemming from the degeneration effects of alcohol."<sup>67</sup> Why all the confusion? Much of dishonesty is denial and denial is part of the disease of Alcoholism. The court missed the simple issue.

In People of the State of Colorado in the interest of C.S. and concerning E.S.,<sup>68</sup> the court used the following language:

"... he has failed to comply with or follow any of the recommendations of the Court or the Department of Social Services to cure the illness of alcoholism."<sup>69</sup>

The court speaks in terms of "curing" the illness of alcoholism. If any basic study had been accomplished, the court would have known that, although it is treatable, and thereby arrestable, alcoholism is not curable. This concept is best described by a common expression used by many recovering alcoholics in the Alcoholics Anonymous (AA). "You can't unmake a pickle."

We legally trained professionals who are knowledgeable regarding this devastating disease have a moral, if not ethical, duty to educate our fellows. Sound arguments, succinct briefs,<sup>70</sup> and articulate experts do much to edify the courts. As knowledge and understanding grow, the legal system will become an increasingly important part of the solution to this massive societal problem.

#### Derived Definition

From the foregoing discussion and analysis, it is patent that an effective workable definition must be characterized by brevity, clarity, reasonable inclusiveness, reference to the use of alcohol interfering in the drinker's life, and the existence of denial. I offer the following as such a definition:

Alcoholism: A disease in which the drinking of alcohol substantially interferes with one or more important parameters of the drinker's life. An important characteristic of the disease is the denial of that very life interference.<sup>71</sup>

This original definition is offered for the reader's consideration and for comparison with the reader's own definition. To meaningfully understand the disease, it is often useful to derive one's own definition.

Efforts toward that goal can only improve the reader's understanding of the disease and effectiveness as a legal "Gate Keeper."

### PART III IDENTIFYING THE DISEASE

After reading Part II, the reader will be reasonably knowledgeable concerning the disease of Alcoholism; its complexities and society's hesitation in dealing with the problem.

In this section, that basic knowledge will be built upon in developing a "how to" approach to identifying the alcoholic as he makes his way through the legal system. Practical diagnostic techniques will be presented and discussed. These techniques and insights can markedly improve: counsel's ability to represent his alcoholic clients; judges' ability to make appropriate dispositions of alcoholic defendants; and correction, parole, and probation officers to accomplish their assigned tasks regarding alcoholic subjects.

Several years ago, I represented a senior military officer in a very serious criminal proceeding.<sup>72</sup> Prior to my taking over the case, he had been found guilty of the charge at a General Court-Martial and sentenced to a Dismissal (corresponds to a Dishonorable Discharge for an enlisted man). Appeals had been taken to the Court of Military Review and the Court of Military Appeals.<sup>73</sup> Both courts affirmed the conviction and the sentence. By the time I read the record of trial, my client was about to be separated from the Navy. The only proceeding remaining in this case was a hearing before the Clemency and Parole Board.<sup>74</sup> This Board has the power to recommend clemency in such cases, and if it does, the Service Secretary usually follows the recommendation. The hearing was scheduled for one



week after I was assigned the case. If the Board recommended no clemency, the Service Secretary would approve the case, and my client would be separated from the service immediately, with no retirement or other benefits. At the time, he had eighteen years of active duty.<sup>75</sup>

After having read the foot-thick record of trial and studied the circumstances surrounding the offenses, it appeared that the offense had been committed while my client was very intoxicated. The complaining witness was intoxicated and some other people present were also intoxicated. It had been a very wet party.

My client had an exemplary past record with only one small "grey" spot. Some eight years prior to the instant offense he had "lost his car" while drinking, and had organized a search party of his troops to try to find it. He received some very minor corrective action for that incident and nothing more was said.

It should be noted that the record of trial, and all subsequent pleadings, were devoid of the mention of Alcoholism or alcohol abuse. No theory or argument ever mentioning Alcoholism or alcohol abuse was employed.

I added up the evidence; the instant offense was committed while my client was intoxicated; my client claimed he had a very vague memory of some of what happened (blackout?); his only prior trouble had been due to intoxication (the lost car); and he didn't remember the car's location (blackout?).

With my meager, but probative four points of circumstantial evidence, I asked for, and was granted, a continuance of the hearing. I then contacted my client, who was stationed 1500 miles away and whom I had not yet met. At my request, he flew to Washington, D.C., where we sat down and talked about his case. Through that interview, and some

diagnostic techniques I will present later in this paper, he became aware that he might have an alcohol problem, and that the actions that led to his conviction might have been the result of that problem. I was convinced he had the disease and after he considered the options, he authorized me to make an appointment for him to be evaluated by medical professionals and, subsequent to their positive diagnosis, to enter treatment for Alcoholism. The Clemency and Parole Board hearing was continued again, in view of his treatment.

After his in-patient treatment was complete and he was well-established in his maintenance program in Alcoholics Anonymous, we went to the hearing. My client testified that he would not have done what he had done if he had been sober. He also testified that he now knew he was an alcoholic and had a program by which he could stay sober one day at a time. The treating physician, also a recovering alcoholic, testified regarding the disease in general and how it affected my client specifically. He also suggested that as long as my client did not drink, there was no reason to believe that a similar incident would ever happen again.

Although the Board decided against my client on a split decision, the minority opinion was so strong that the Service Secretary suspended the sentence, allowing my client to remain on active duty until he was retirement eligible. My client was then retired with full pension and retirement benefits.

I do not relate this story for self-engrandizement, but rather to point out how important it is to see the disease. In the two years in which that case had been ongoing, before I took it over, not one person had documented the relatively clear signs of Alcoholism.

When such cases occur, it brings home the gravity of the problem and how many cases may have slipped by. Commander Jerry Bunn, U.S. Navy, Director of the Navy Alcoholic Rehabilitation Center, San Diego, California, illustrates a sad example,

I just had [some]one here two weeks ago ... a child psychologist, marriage family counselor, but his speciality was child psychology, practicing here in San Diego for years. [He] didn't know twit about Alcoholism. [He] came here to do some post-doctoral work as an intern, and within three weeks, he walked in [my office], literally in tears, saying he just sat home the night before going through some of his old cases, and 90% of the cases he'd missed totally ... alcoholism was impacting on the family, ... killing the kids. "All my education and I never saw it, until I spent three weeks here working with a bunch of drunks."<sup>76</sup>

In the following discussion, I point out the signs and symptoms of the disease as we encounter it every day in our law practices.

#### The Lawyer's View

As lawyers, many times we are the first professionals to see the alcoholic when the disease is patent. The alcoholic may have been successfully conning his physician through his yearly physicals, and when he sees his clergyman, he is careful to act the image of the proper vestryman. However, when he sees his lawyer, he usually has a problem. If the client is an alcoholic, his problem will probably be alcohol related.

We can receive information from a client in many ways; by what he says, or what he does not say, by a look, a tone of voice, an eye, the appearance of nervousness, or even perspiration. When speaking with a possible alcoholic, our tacit communication links should always be sensitized.<sup>77</sup> Beware of the "double message." That is, the person saying one thing, but the same person signaling something quite different tacitly. When this happens, the communication is not clean; the communicator is hiding something. Practicing alcoholics almost always deliver "double messages." As they

start to recover, this defect disappears. If the basic character of communication with a particular person is confusion and discomfort, Alcoholism is a likely cause.

#### Identification by Legal Problem

The most obvious diagnostic tool we have available is the character of the client's problem. If the charge against the client is Driving While Intoxicated or Driving Under the Influence, there is a good chance that the client is an alcoholic. After all, such a charge is a substantial interference in his life. Of course, he just could be one of the unlucky ones; at least, the first time.

If, in the course of the interview, you discover that the client, Mr. X, has had previous charges for Driving While Intoxicated, you can be almost assured he is an alcoholic. Likewise, if his blood alcohol was elevated beyond .20,<sup>78</sup> he is almost assuredly an alcoholic. Such a high blood alcohol level, combined with evidence that a person is still functioning shows tolerance. Tolerance almost defines<sup>79</sup> Alcoholism.

A former client of mine once rolled a motor-home over on its side at three o'clock in the afternoon. His blood alcohol level was .46. A normal non-alcoholic drinker would not only be comatose at that level, but likely be dead. Yet, he was driving a large motor-home. This is an extreme example of tolerance.

If denial is present to any degree, alcoholism should be suspected. If the "Driving While Intoxicated" client, Mr. X, reacts reasonably to questions regarding his use of alcohol, he may be one of the few "just unlucky" normal drinkers who got caught driving

under the influence of alcohol once. If his blood alcohol is between .10 and .15, he has no prior offenses, and he readily accepts a suggestion to look into his drinking habits, he probably is not an alcoholic. If, however, he vehemently denies abuse of alcohol, blames the police, and has a substantial blood alcohol level (i.e., .020 or above), then Alcoholism is patent.

Drunk driving offenses, of course, are the easy ones regarding identification. More difficult are the offenses that do not by necessary implication involve Alcoholism but, to the trained observer, are strong indications in the majority of cases. Spouse abuse, child abuse, assault, many related violent crimes are often Alcoholism involved.<sup>80</sup> When handling such a case, the client should be questioned thoroughly regarding his alcohol use. If denial is immediate and vehement, Alcoholism is probable. Combine the facts of the case with denial; add the statements of the witnesses; and you have an almost sure case of Alcoholism.

There is another class of offenses, the commission of which is strong evidence of the disease of Alcoholism. I refer to the strange or aberrant kind of offense when considering the character of the perpetrator and the circumstances.<sup>81</sup> The meak little bank teller who attempts rape, the accountant who exposes himself in downtown Washington, D.C. at 2 a.m., or the big rugged married Army sergeant who makes a homosexual advance, are examples of this "strange case" syndrome.

These cases are out of character for the individual involved. Although such behavior can have other causes, Alcoholism should always be suspected and investigated. Dr. Purvis explains this phenomenon this way:

It affects the intellect, because alcohol works on the brain exactly like ethyl ether ... The reasoning and judgement are first

impaired; the area of the brain responsible for reasoning and judgment, is the first that goes off the line when a person drinks. Therefore, the very, very bright well-controlled, intellectually controlled, rational human being, sober, gets a few drinks in him and becomes mildly irrational; takes three or four more drinks, becomes markedly irrational; and a few more drinks, he becomes totally irrational and ends up either in a mental hospital, in an accident or in jail ... It occurs to me that a person who is drinking, who when not drinking, is a pillar of the society, and while drinking ends up in jail and mental hospitals, has a problem. Whether he wants to admit that he has a problem is not important. What's important is that, in reality, there's a problem.<sup>82</sup>

#### Identification by Physical Manifestation

Everybody knows what a drunk looks like! We have seen that this is not necessarily true, since a drunk (alcoholic) looks pretty much like any other human being. However, some of the physical manifestations of Alcoholism, in its later stages, are well known to the general public. The "red-nosed" alky, the shaky wino, and the town drunk, are almost folk heros. Sayings like "The Lord invented whisky to keep the Irish from ruling the World,"<sup>83</sup> are all parts of that general familiarity we have with the physical manifestations of the alcoholic. Notice the dichotomy of society's acceptance of the town drunk and the avoidance of the serious discussion of the problem of Alcoholism.

There are significant physical manifestations of Alcoholism, and awareness of these are essential for effective diagnosis. By physical manifestation, I do not include "Chronic Disorders due to Prolonged Usage,"<sup>84</sup> such as Alcoholic Polyneuropally,<sup>85</sup> Wernicke's Encephalopathy,<sup>86</sup> or cirrhosis of the liver.<sup>87</sup> These conditions arise from long-term, untreated, Alcoholism and are, generally, irreversible.

The focus of this section will be the acute manifestations which can be easily discovered if the observer is sensitive to the disease process. If the client's disease has progressed sufficiently to start to show physical manifestations, the well-trained professional

will not miss the diagnosis. The sufficiently progressed alcoholic client can be in various conditions when he arrives at the lawyer's office for his appointment. If it is in the morning, and he is determined to present a sharp, cogent appearance, or has sworn off liquor for a short time, he will usually be in withdrawal and will appear flushed, have red road-mapped eyes (Injected Conjunctiva),<sup>88</sup> be agitated, and have difficulty sitting and or concentrating. His hands will also be in a tremulous state, varying from slight to obviously shaking. His mood is likely to be hostile and aggressive, sometimes to the point of violence.

An alcoholic American Indian, who was a career enlisted man in the Navy, with some 18 years of active duty, came into my office one day, because he refused to be evaluated for Alcoholism at the Navy hospital. He explained to me that if he were ordered to go to the Navy hospital for that evaluation, that he would not follow the order, and that he would get out of the Navy. He also told me what I could do with my Navy. I tried to reason with him. However, the more I talked, the more disrespectful he became. Physically, he had every one of the symptoms discussed. Before he realized the inevitability of his evaluation, he came very close to physically assaulting me. That would have been unfortunate under any circumstances but, under the then present circumstances, it would have been disastrous. I was the Staff Judge Advocate at the Naval Station, San Diego, at the time, and his superior officer. Had he struck me, not only would I have been seriously hurt, since he was so powerful, but a General Court-Martial could not have been avoided, with a probable consequent Dishonorable Discharge and time

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in prison. The agitation and hostility, accompanying the withdrawal, was manifest to such an extent that he almost committed an act he would never normally consider. He did eventually go for the evaluation; they kept him at the Alcohol Rehabilitation Unit, and the last time I saw him, he was recovering satisfactorily and looked relatively healthy.

The symptoms of withdrawal can become serious. Delirium Tremens (DTs),<sup>90</sup> hallucinations,<sup>91</sup> and Alcoholic convulsions (Grand Mal Seizures),<sup>92</sup> can all result from acute withdrawal. These are dangerous conditions and require hospital care. Without hospitalization, 15% of the patients that enter Delirium Tremens die.<sup>93</sup> It is not beyond the realm of possibility that an alcoholic client could go into such an acute withdrawal state while he was in the lawyer's office. Should such a thing happen, it is essential to get medical help immediately. Some experienced counselors, who specialize in treating alcoholics, have a bottle of whiskey handy in their offices. If and when an alcoholic appears to be going into acute withdrawal syndrome, they give the alcoholic enough whiskey to help him out of physical withdrawal until medical help can be secured. Supplying alcohol to the alcoholic under these circumstances may facilitate a long-term recovery, save a life, and avoid a great deal of damage to office furniture, rugs, etc.<sup>94</sup>

If the alcoholic arrives at the law office having had a bit of "liquid courage," his symptoms will be quite different. He is liable to be affable and relaxed. His eyes will probably still appear red-veined, but his hand tremors will not be noticeable. He will have no difficulty in sitting and his anxiety level will be low. He may be very cooperative and appear to comprehend everything you say. Only when you approach closer than three or four feet from him will he appear anxious and



attempt to avoid your glance. This is because he is worried that you might smell his "eye opener" and realize he had been drinking before his appointment. It should be noted that the morning drink for the alcoholic is often vodka, because of its lack of definitive odor.<sup>95</sup>

Therefore, if you do smell the client's breath, it may not be the clear smell of whiskey or gin, but a faint sour smell that cannot be mistaken for toothpaste. Of course, the smell is secondary; the real symptom is the avoidance of proximity. Since the alcoholic is naturally secretive and concerned that he should not be found out, if he drinks in the morning or during the day, he tends to use mouthwash or breath fresheners in great quantity. If you find your client reeking of mouthwash and aftershave, while looking at you through road-map eyes, it is likely that he has the disease. As strange as it seems, alcoholics will occasionally supplant the morning drink with a drink of mouthwash itself. Commercial mouthwash varies in alcohol concentration from 5% to 35%. Drinking mouthwash, with substantial alcohol content, is as much an eye opener and nerve settler as a gulp or two of vodka. This mouthwash syndrome reached its high point in a situation reported to me by a friend, who is a U.S. Navy submarine officer. It seemed that a Chief Petty Officer (E-7) assigned to the same submarine had the reputation of being quite a heavy drinker in port, but never failed to be on board when he was supposed to be and always was available to do his job at sea. Since alcoholic beverages are prohibited on board U.S. Navy ships, he apparently went on the wagon, cold turkey, whenever the ship was underway. However, he never seemed to experience hang-overs or withdrawal. It was discovered that he bought great quantities of a particularly medicinal mouthwash from the ship's store during each

deployment, and when he come on board, he always carried a case or two of this same mouthwash with him. The Chief, reportedly, always had sweet breath and calm nerves. Here is an example of how an alcoholic will always get a drink if he needs it, despite the laws or regulations.<sup>96</sup>

There will occasionally be the case of easy diagnosis. If the alcoholic client takes a little more "eye opener" than he needs to quiet his nerves, he will show the traditional signs of alcohol intoxication; slurred words, unsteadiness, inability to think clearly, and eventual unconsciousness. In this case, the diagnosis can be prevented only by the attorney's playing the enabler, making excuses, etc., the dangers of which have previously been discussed. It is to be avoided at all costs.

An extremely important piece of probative evidence regarding the existence of the disease is the presence of the "blackout." The alcoholic blackout is a most misunderstood syndrome.

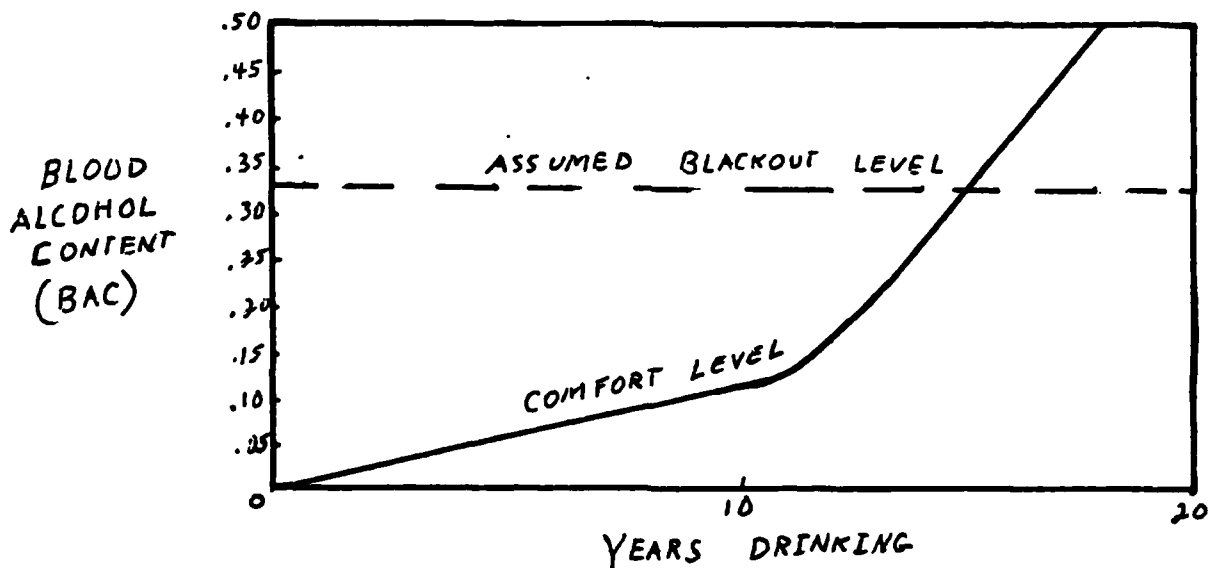
As the illness progresses ... "blackouts" become a common phenomenon, episodes in which the alcoholic has temporary amnesia for various periods of time during which he has been imbibing.<sup>97</sup>

By "temporary amnesia," it should be understood that the alcoholic is permanently unable to remember certain events that may have taken place, but the period of blackout or non-rememberance is temporary. That is, the alcoholic can go in or out of the blackout over a period of time. It seems to be related to the level of blood alcohol for a particular individual, but it is not absolutely correlative. The most important thing to remember about the blackout is the fact that it is real. No recollection of the events taking place during the blackout is made in the brain. It seems not to be a psychological suppression mechanism causing sub-conscious loss of memory. There is, in fact, no memory during the blackout.<sup>98</sup> One hears a person speak of "blackout" as

when the "curtain fell." I have heard recovering alcoholics speak of going into a blackout in Boston and coming out of the blackout driving a car in California three days later!

The alcoholic in the blackout can act normally. He can drive a car, go to work, meet new people, take part in sports, even fly an airplane.<sup>99</sup> He can accomplish such tasks successfully, and not remember a thing about them.

Blackouts are a definitive sign of Alcoholism. Drinkers who experience them on a regular basis are almost assuredly alcoholic. In most people, blackouts correlate to tolerance. In fact, a measure of the progression of the disease is the range of the comfort level as measured by blood alcohol between freedom from withdrawal symptoms and blackout. As the disease progresses, this range gets narrower. The graph below is expository:



(Graph presented for conceptual purposes only: BAC, years drinking, and blackout level vary with each individual alcoholic.)<sup>100</sup>

From the graph, it can be seen that in some cases, the alcoholic never remembers the time when he feels good, because in order to reach

comfort level, he is already in a blackout. This, of course, is in the later stages of the disease. The alcoholic will either soon reach his "bottom" and start the recovery process, or he will die, or go insane.

Most important for the lawyer is to realize that the first stage of the blackout syndrome can start early in the disease, and, it is real. No amount of searching or questioning will bring out the events that took place during the blackout because they are unrecorded. Of course, care should be taken to insure that the blackout story is not being abused. The client may really remember, but refuse to tell the truth, or, perhaps, has subconsciously buried it and incisive questioning can bring it out.

Another telling physical manifestation of Alcoholism, and one that is closely related to the blackout, is the mysterious injury. If you see a client with a black eye, a swollen nose, or a sprained ankle, he should normally be able to explain how he received the injury. An alcoholic may not be able to tell you. If the injury happened during a blackout and the trauma did not bring the alcoholic out of the blackout, the alcoholic will not know the cause of the injury.

Alcoholism and Trauma are so commonly linked together that Dr. Zuska, in his article, Wounds without Cause, recommends that you "Look for alcoholism in every traumatic crisis and arrange for appropriate referral when indicated. A routine BAC (blood alcohol content) will often point to alcoholism when unsuspected. Include the diagnosis of alcoholism on charts and death certificates. Alcoholism is a disease, not an accusation, and is grossly under-reported."<sup>101</sup>

In interviewing a client, discussing seeming irrelevances can do much to supply a complete picture of the client. As Dr. Purvis

observed earlier, people who don't have a problem with alcohol don't consider quitting. The budding problem is evidence of the disease. In this same vein, a subtle clue may be a change in drinking habits. The statement, "I don't drink the hard stuff anymore, just beer and wine," or "Martinis are too strong, I switched to Scotch and Soda," are subtle signs of what may be a well developed problem at present. The book, Alcoholics Anonymous gives some insight into the issue.

... We have tried hard enough and long enough to drink like other people! Here are some of the methods we have tried: Drinking beer only, limiting the number of drinks, never drinking alone, never drinking in the morning, drinking only at home, never having it in the house, never drinking during business hours, drinking only at parties, switching from scotch to brandy, drinking only natural wines, ...<sup>102</sup>

If a person is so involved with alcohol that he will go to the extent to experiment, make rules for himself, or only drink certain drinks under certain conditions, alcohol has great importance to that person. If string beans were causing a life problem for an individual, wouldn't that person just decide to quit eating string beans? When alcohol causes a life problem for an individual, he usually tries to find a way to continue to use it and avoid the problem. As a matter of fact, "The idea that somehow, someday, he will control and enjoy his drinking is the great obsession of every abnormal drinker."<sup>103</sup>

If in an interview with a client, evidence of modification of drinking habits emerges, it may indicate the presence of the disease. If this evidence is coupled with the usual answer to the question, "How much do you drink?", that is, "A couple," the diagnosis of Alcoholism becomes more likely. When you ask the question, "A couple of what?", if your client looks uncomfortable, that is even more evidence.

As a final note in diagnosing by physical manifestations, denial must again be mentioned. It is absolutely essential for an attorney to keep the denial mechanism in mind when he is interviewing his client. The evidence of the disease may be patent; however, many times it will be communicated tacitly and by the denial mechanism. In Adams v. Wienberger, the court dealt with the issue appropriately when it stated, " 'The quitting drinking, there is no great problem there. Well, I enjoy it, and I don't—I don't think the beer hurts me, particularly.' Such testimony may be relevant if, medically, the claimant has the power to control his alcoholism; otherwise, the statement represents the rationalizations of a sick individual who does not realize the extent of his illness."<sup>104</sup>

The court here was dealing with the alcoholic's denial of his disease. As can be seen from the prior discussion of denial, it exists in all manifestations of the alcoholic's relationship with alcohol. The court on Gray v. Califano, went so far as to explain away a party's failure to raise his Alcoholism in a psychological examination by reference to the denial syndrome.

Both sides here concede that Mr. Gray is a chronic alcoholic, therefore, his failure to raise his Alcoholism problem during the psychological examination comes under the rule of Adams, and should be given little, if any, weight.<sup>105</sup>

In dealing with potential alcoholic clients in our offices, we should be especially sensitive to what is not said and what is denied. Many times we are able to discover the clues we need from their non-communication.

#### Identification by Home Life

The first signs of the disease of Alcoholism usually show up in the alcoholic's home life, in his relationship with his mate. Dr. Zuska says,

... it's the intimacy between two persons.  
That's really the first place that gets hurt.  
And then later on, the health and the job ...<sup>106</sup>

This relationship is, of course, the most private, secretive area in anyone's life, so that discovering these problems is most difficult. However, it is worth investigating. Such questions as, "How are you and your wife getting along?" are not unreasonable and the reaction to such a question may be very telling. If you are met with hostility and/or denial, that is a possible sign of the disease as well.

As the disease progresses, family problems will become more obvious and the alcoholic is liable to be more verbal regarding them. The alcoholic will perceive the problem as the fault of the other family members. The other family members will see the problem as all the alcoholic's fault. The truth is that the problems are a function of the disease. The disease of Alcoholism is a family disease.<sup>107</sup> That is, it affects not only the pathological drinker, but it also affects his family as well. (It also affects friends and acquaintances.) Estimates vary, but for every person who suffers from the disease of alcoholism, diagnosed or not, four to eight other people are directly affected. Further discussion of Alcoholism as a "family disease," and the treatment therefore, will take place in a later section of this paper which deals with recovery from the disease.

For our instant purposes, however, titular knowledge of the existence of the "family disease" concept and the effects of Alcoholism on the "significant others" in the alcoholic's life, is necessary. Family difficulties and the breakdown of relationships are all good evidence of the disease that can be discovered through an interview in the lawyer's office.

If the client is having substantial marital problems or has temporarily moved out of his home (away from his family), alcoholism should be

considered. If the client makes vociferous complaints about lack of understanding at home, then further evidence of the disease is present.

Alcoholism is an expensive disease and the practicing alcoholic is liable to be in a financial debacle. This is true even if his income is substantial. Somehow, the money just slips through his fingers.<sup>108</sup> The cost of liquor is only part of the expense. Buying for everyone at the bar and losing money are other methods by which the finances become critical. In many families of alcoholics, children take on behaviors that would normally be unexpected and seemingly out of character with their upbringing and education. The psychiatrists and psychologists call this activity "acting out."<sup>109</sup> In fact, the child takes part in this anomalous behavior, be it criminal, destructive, or self-destructive, to get attention and to "act out" his or her frustration. Such behavior in children is a very good sign of Alcoholism in the family.

When the family discord reaches extreme levels, the situation reaches the point of potential "tissue damage."<sup>110</sup> When physical assault and battery among members of the alcoholic's family starts to take place, the evidence of the disease becomes patent. As we have seen, statistically, a large percentage of assaults are committed when the assaulter is intoxicated. A lesser known fact is that assaults committed by family members against the intoxicated alcoholic are also common. When people in the same family start beating each other, there is a substantial problem; more often than not, Alcoholism.

In the book, Alcoholics Anonymous, the home life of the alcoholic is described thusly:

Our loyalty and desire that our husbands hold up  
their heads and be like other men have begotten  
all sorts of predicaments. ...Our homes have



been battlegrounds ... We seldom had friends at our homes ... There was never financial security, positions were always in jeopardy ... They struck children, kicked out the doors ...<sup>iii</sup>

Such turbulence in the home will usually be covered up.

However, in the discussion at the law office, a client will sometimes share parts of his home life. He may not think he is being relevant; however, to the perceptive practitioner, the client's small admission of his disjointed home life, can be valuable evidence of the disease.

#### Identification by Checklist

In almost every pamphlet, book, or article, dealing with alcoholism, there appears a list of "danger signals," "signs of the disease," or "questions to ask yourself."<sup>112</sup> These questions, indicators, or checklists are often helpful. The best ones generally contain many common elements. Drinking alcohol to excess, blackouts, interference with life goals and activities, anomalous behavior, and problems at home, are among these common elements. While these checklists are potentially useful; they can only be employed successfully as self-quizzes for the client after subjective evaluation has taken place, and a modicum of confrontation has been accomplished. The attorney can refer to the checklist anytime for his own evaluation of his client. Usually, however, such usage will be unnecessary if the attorney is knowledgeable about the disease and has observed his client at any length in accordance with the guidelines in this paper. The real value of the checklist is in giving it to the client for his self evaluation. If a crack in the client's denial armor has appeared, the checklist may be instantly successful. If not, the alcoholic client will remember the checklist; he may take it with him, and at a later time it may do its work. The recommended technique, then, is to present the client with the checklist after a subjective

evaluation; after, you as his attorney, have a good indication that he suffers from the disease. When he asks for help, indirect as that request may be, the time is right to suggest a little quiz. Of all the check lists available, among the most effective, the simplest, the shortest, and most complete, is a pamphlet consisting of twelve questions titled, Is AA for You?. The questions and scoring information appearing in the pamphlet appear below:

- |  | YES | NO  |
|--|-----|-----|
| 1. Have you ever decided to stop drinking for a week or so, but only lasted for a couple of days?                              | ( ) | ( ) |
| 2. Do you wish people would mind their own business about your drinking -- stop telling you what to do?                        | ( ) | ( ) |
| 3. Have you ever switched from one kind of drink to another in the hope that this would keep you from getting drunk?           | ( ) | ( ) |
| 4. Have you had a drink in the morning during the past year?   | ( ) | ( ) |
| 5. Do you envy people who can drink without getting into trouble?  | ( ) | ( ) |
| 6. Have you had problems connected with drinking during the past year?   | ( ) | ( ) |
| 7. Has your drinking caused trouble at home?   | ( ) | ( ) |
| 8. Do you ever try to get "extra" drinks at a party because you do not get enough?   | ( ) | ( ) |
| 9. Do you tell yourself you can stop drinking any time you want to, even though you keep getting drunk when you don't mean to? | ( ) | ( ) |
| 10. Have you missed days of work because of drinking?  | ( ) | ( ) |
| 11. Do you have "blackouts"?   | ( ) | ( ) |
| 12. Have you ever felt that your life would be better if you did not drink?  | ( ) | ( ) |

## WHAT'S YOUR SCORE

Did you answer YES four or more times? If so, you are probably in trouble with alcohol. Why do we say this? Because thousands of people in A.A. have said so for many years. They found out the truth about themselves — the hard way.

But again, only you can decide whether you think A.A. is for you. Try to keep an open mind on the subject. If the answer is YES, we will be glad to show you how we stopped drinking ourselves. Just call.

(Reprinted with permission of AA Work Services Inc.)

On several occasions, I have facilitated an alcoholic's recognition of his disease through the use of this pamphlet.<sup>113</sup> If an alcoholic answers the questions with a scintilla of honesty, doubts regarding the existence of the disease will be quickly dispelled. Among others, I used this pamphlet in facilitating the self-recognition of the senior officer I represented, as discussed earlier. Timing is all important in its use. If you suggest the test to the alcoholic client too early, he will rebel and perhaps become so hostile as to fire you as his counsel. If you wait too long in letting him take the test, valuable recovery time may be lost with consequent physical, emotional, and mental damage. If in doubt, whether to give the test, it should be remembered that the alcoholic may reject today what saves him tomorrow. In erring then, err on the side of giving the test too soon. One never knows when a seed of self-recognition will bear fruit.

### New Horizon in Diagnosis

<sup>114</sup>  
In Biochemical and Hematogenous Correlates of Alcoholics, a recently published article, the authors report the results of extensive testing and correlation of blood chemistry of alcoholics and non-alcoholics. In a very sophisticated mathematical analysis, through numerous chemical tests, a blood "profile" for the alcoholic was developed. This profile

is discriminate and definitive. It may be developed as a screening test, and become as routine as an EKG at an annual physical. Of course, in case of a positive result, denial may still prevent the alcoholic from accepting his disease and from beginning recovery, but the existence of the disease will be objectively proven. Since the existence of the disease will then be known by his physician, maneuvering the alcoholic toward recovery can be commenced.

Although the test is still in its infancy and relatively unavailable, if it proves reliable on a large scale, it will most assuredly become common. The result of such a test would be invaluable to the lawyer representing a possibly alcoholic client.

#### The Judge's View

The judge is in a somewhat different posture than is the lawyer regarding his ability to see alcoholism in a person before him. He lacks the time and the subjective exposure to the individual that the lawyer enjoys. Yet, he may have more objective evidence than the lawyer has; the pre-sentencing report, the rap sheet, and any other special privileged information available to him. He is more likely to be able to see through the conning of the alcoholic before him, partially because of the number of alcoholics that come before him and partly because of his objective stance. He is not on anyone's side. Therefore, his view is likely to be unbiased and clear.

The judge can use all the indicia of the disease previously discussed. The alcoholic will appear in court in the same stages of dishevelment that he appears in the lawyer's office. He will try the same lies and excuses in court as he does in the lawyer's office. However, the Judge must be faster to diagnose than the lawyer. Initially, the lawyer may be covering and minimizing the client's problem. He also

may not see the problem. The client may have "conned" him completely. The judge who can see this situation from the bench with clarity and alacrity will be more able to make an appropriate disposition of the case, both helping the alcoholic and ensuring that the interests of society are protected. Such a judge is the Honorable Bill Beard, Judge of the Unified Court of the City of El Cajon, California. 115

Regarding diagnosis from the bench, Judge Beard says:

You can't sentence anyone on a drunk-driving charge without seeing his rap sheet.

The law requires you to look at the record before you sentence. This goes for drunk-driving; it also goes for everything else. I just look at rap sheet ... .

It will usually tell you. The alcoholic will show up. It will start as a juvenile; all kinds classic types of cases such as failures to provide, checks, assaultive behavior, drunk in public, failures to appear. Lack of responsibility. This will tell you pretty much his background. 116

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Judge Leon Emerson, Municipal Court Judge for the Downey District of Los Angeles County, is one of the leading judicial experts on alcoholism and appropriate sentencing for the alcoholic in the country. He has lectured extensively on the subject nationally, and gave a major presentation at the 1980 International Convention of Alcoholics Anonymous in New Orleans, Louisiana. His views regarding diagnosis from the bench follow:

... the most important thing for a judge is ... learning how to diagnose, and you've got to do it very fast. ... the arraignment calendar is the first entry in the criminal justice system. About 90% of all the alcoholics plead guilty at the arraignment, at the entry system. So you've got to do a diagnosis ... I sort of put them in four categories: One is social drinkers and I don't think ... [they've got] a problem — we're talking about alcohol-related offenses. The next are problem drinkers — they've got a problem, they need education, but probably don't need to lose their driver's license.

... A good educational program will be okay. The serious problem drinkers, or the alcoholics, that's difficult to define. I define the chronic alcoholic as the guy who really ... is a real sick guy. So there's four categories basically as the way I define them.

And I can pretty well pick those out of the population ... blood alcohol content of less than .15, it's pretty much the social drinker. I believe ... — anything beyond .12, you should take a look at, but I use .15 for safety's sake ... I'm talking about drunk drivers, because the common drunk, the check writer, the burglar, wife beater, we don't test on those, so I have to look at other things. It's a little tougher diagnosis, and I go through a questioning system ... asking them some questions and have them fill out some questionnaires, to give me some idea.

First of all, the blood alcohol content, when you've got it, is the best indicator. Numbers of arrests is the second best indicator, and then third best indicator is talking to them about alcoholism, or they'll con you out of your eye teeth, because alcoholics lie a lot, good con men, as you know ... this is the problem with an ordinary street judge who has not studied alcoholism or has never been to an AA meeting ... he can go on for years and years and years on the bench, totally ignorant of alcoholism, and totally ignorant of the gameing that alcoholics and addicts will do to him ... They don't realize they've got a problem, so they don't study it ... the first time one or two of them [Judges go] to an AA meeting, they discover — they start gleaning the very nature of alcoholism, they wake up real fast, and very often start studying.

Go back to the diagnosis. Using the blood alcohol content, I have a sort of a rule of thumb that I use on diagnosing. Anybody under .15, I sort of put ... in a social drinking category. Yet, they have a problem in the fact that they have been arrested and brought before this court. I know that the ordinary social drinker doesn't drink more than 2 or 3 drinks, and they don't ever get up to .15. So I know that in all probability that, [with] 4 or 5 drinks, that person is already developing tolerance, is already becoming a problem to himself.

Now, the second [time] offender [has] probably ... a two thirds chance of being an alcoholic. The fact that he's had one prior arrest; that alone tells you, no matter what the blood alcohol content ... [however, the usual blood alcohol content on the second offender comes in somewhere between .15 and .25.

Almost everybody that has a blood alcohol content of .20, and I've had like a dozen exceptions in 20 years that I knew of — practically everybody with .20 or greater is an alcoholic, because that's about 10 or 15 drinks in his person depending upon his size.

You know this person is not a social drinker. He's got a very high tolerance and really yards them in. The exception seems to be when you get a batchelor party [and] everybody sees how drunk they can get the prospective groom, and everybody gets drunk with him.

The drinking party, the fraternity party, ... — the beer pull, everybody seeing how drunk they can get. Sometimes Chicano weddings are very much a drinking episode and so I don't regard that as necessarily being alcoholic.

But, [with these exceptions], anybody with a blood alcohol content of .18 or .20 is definitely an alcoholic, and they go into an alcoholism ... treatment program.<sup>118</sup>

Both Judge Beard and Judge Emerson are valuable fonts of knowledge and experience. In the portion of this paper addressing rehabilitation of the alcoholic, their procedures are reported in substantial detail.

So it is that the judge has perhaps a more difficult job diagnosing the alcoholic than does the lawyer, since he spends less time with him. However, as we have seen from Judges Beard and Emerson, it is possible to make this quick diagnosis. The rewards of investigating the presence of the disease are immense when determining an appropriate sentence or treatment plan.

Failing to consider the presence of the disease, likewise, can end in disaster for the defendant. Sentencing for the substantive crime, but with a view toward therapy for the disease, can satisfy the retributive needs of society, the specific and general deterrence requirements, plus the rehabilitation needs of the sick individual. If the sentence is appropriate, with provision for treatment and recovery, residivism could be substantially reduced.

#### The Post-Trial Professional's View

The corrections officer, probation officer, and parole officer are in particularly important positions to facilitate the recovery of an alcoholic.

Many times, the conviction, sentencing, loss of freedom, or substantial reduction of freedom, are sufficient to get the alcoholic's attention.<sup>119</sup> Once we have his attention and he decides he may need help, he is on his way to recovery if he knows the nature of his problem and understands where to go for help. Here is where the wise post-trial professional can be of assistance.

If the corrections, parole, or probation officer is knowledgeable regarding the disease and sees the signs of the disease, as we have discussed, he has the time and opportunity to counsel the alcoholic at length. The case of the alcoholic who is incarcerated provides unique opportunity for productive counseling. Through asking the alcoholic questions and allowing him to discover why he really ended up in jail, his self-realization can be facilitated. Of course, the AA 12 Questions (reprinted earlier), can be presented at the appropriate time. Once self-realization takes place, and the alcoholic accepts the possibility that he might have the disease, he may be ready for a recovery program. The critical position of the post-trial professional in the alcoholic's recovery cannot be overestimated. He is the person with whom the alcoholic convict will spend the most time. He is the person who will be the closest to the convict when he is most depressed and perhaps at his emotional "bottom." He will be in a position to guide and lead the alcoholic to a program of recovery if he understands the disease. Much rehabilitation can be accomplished while the convict is incarcerated or under supervision. In the next section of this paper, those opportunities will be discussed.

#### Concluding Remarks on Identification

In the U.S. Navy's alcoholic rehabilitation program,<sup>120</sup> emphasis is placed on identification and referral of the possible alcoholic. A



portion of the implementing instruction is reprinted below:

3. Identification and Referral. To facilitate the identification and screening process, commands should:

- a. Acquaint supervisory personnel with the symptoms of alcoholism and alcohol dependence so they can recognize those in need of medical referral. They must use discretion, because many abusers are not alcoholics. Medical officers can be helpful in teaching supervisors by providing laymen's explanations of symptoms covered in Department of the Navy Publication NAVMED P-5116, Section VII and Appendix E.
- b. Require all medical officers in the command to familiarize themselves with the "Criteria for Diagnosis of Alcoholism" (NAVMED P-5116, Appendix E) and other pertinent references and BUMED guidance.
- c. Educate all personnel about alcoholism to enable, where possible, self-identification and voluntary requests for treatment.
- d. Cooperate with the Commander, Naval Safety Center, in the establishment of Alcohol Safety Action Programs (ASAP) for execution at the local level, to identify drunk drivers and other members involved in alcohol related traffic accidents, violations, etc., in order that they may be adequately counseled and, where necessary, treated.
- e. Cooperate with local shore patrol, and military and civilian police in identifying members reported for other infractions of the law involving alcohol, such as drunk in public, drunk and disorderly, altercations, and family quarrels where the member is drunk, etc., in order that they may be adequately counseled and, where necessary, treated.
- f. Make clear entries in officer and enlisted service records stating the nature and extent of alcohol involvement in all disciplinary cases brought to official attention for any reason whatever. This is essential, because frequency and degree of alcohol abuse is a primary means for doctors to differentiate between occasional abusers and those members suffering from alcoholism who must be sent to a treatment facility.
- g. Document uneven or continuously unsatisfactory performance on the part of a member resulting from alcohol abuse.
- h. Refer all apparent alcoholism or alcohol abuse problems to the medical officer for prompt evaluation in order to separate simple abusers, who need remedial education, from alcohol dependent individuals needing therapeutic counseling

and/or treatment at an alcohol rehabilitation facility. Medical officers shall be required to review all available data, record abstracts, medical history and other available records in making diagnoses of individuals referred for suspected alcoholism. Commands having custody of such records are required to make them available to the examining physician for his review at the time of examination.

i. Require members who are found to be alcohol abusers (but who are not diagnosed as alcoholics) to attend remedial preventive education classes, and carry out such disciplinary and/or administrative actions, if any, as the case warrants.

j. In all cases where alcoholism is diagnosed, follow the guidelines provided in paragraph 4 below. If disciplinary action is pending, it should be resolved prior to transfer. After candidly presenting the officer or enlisted member with factual evidence of his drinking problem, commands should consider the judicious use of suspended punishment to channel the individual into an effective alcohol education or treatment program. Punishing an offender without ensuring proper education or treatment, as well as excusing him because of over-indulgence, are both ineffective courses of action in most cases of habitual alcohol abuse. A pending threat of disciplinary action, which can only be set aside by the individual's demonstrated motivation during treatment and satisfactory performance after return to duty, can be beneficial in achieving long term rehabilitation.<sup>121</sup> For example, reducing a man in rating before treatment gives him a feeling of hopelessness and an excuse to drink again because he has "already lost it" — whereas a suspended sentence often provides motivation for abstinence while treatment takes effect.<sup>122</sup>

Commander Jerry Bunn, Director of the Navy Alcoholic Rehabilitation Center, San Diego, California makes the following observation relating to the need for knowledge of the disease of Alcoholism within the legal profession:

Very frankly, I think a lawyer who practices criminal law who doesn't know about Alcoholism probably is holding himself open for a malpractice suit, because ... it's one of the causative factors that you can't miss.

So, until we back it down into the school system that produces the principal movers of the system, the criminal justice system ... the law schools, the police academy ... the medical schools ... the sooner you can impact, ... If you wait until somebody is really set in their ways, and those attitudes that are negative have been reinforced and reinforced, God, it's tough to change.<sup>123</sup>

Commander Bunn's observations are worthy of consideration. Since Alcoholism is such a massive societal problem and since we now have sufficient knowledge to see the problem when it is in our midst, I suggest that our positions as societal "gate keepers" require us to take action toward alleviating the impact of the disease by becoming part of the solution.

#### PART IV FACILITATING RECOVERY FROM THE DISEASE

In the earlier section of this paper, the disease of Alcoholism was defined, discussed, and analyzed. In subsequent sections, guidelines were presented for identifying the alcoholic as we might meet him or her in our everyday practices. In this section of the paper, I will present a discussion of the "gate keeper's" role in the alcoholic's recovery process. Recommendations regarding the most effective modes of functioning for lawyers, judges, and corrections, parole, and probations officers in facilitating the alcoholic's recovery will be discussed.

##### The Recovery Process

Recovery is one of the alternative final stages of the disease. As previously discussed, the others are death, insanity, and/or incarceration. Once the disease process is present, other long-term possibilities are unavailable.<sup>124</sup> Recovery is, then, the only viable alternative. Since the disease is incurable, but arrestable, recovery means living successfully with the disease in remission. The recovery process is the means by which the disease process is arrested and the quality of the life of the person having the disease is progressively improved. The disease of Alcoholism is the only disease in which the patient who is in recovery can get "weller than well."<sup>125</sup> That is, the quality of life of the recovering alcoholic can improve, without limits, ever expanding, becoming more and more enjoyable and productive as his or her recovery progresses. The quality of life of the alcoholic who has been in recovery for a period of time is

almost always better than he or she ever experienced before; even before the disease process commenced.

Recovery is a process corresponding to the disease process. It is gradual and progressive. Fortunately, its progress is usually more rapid than the disease process.<sup>126</sup> Since the disease of Alcoholism is complex, that is, made up of several components, the recovery is likewise complex. Alcoholism has been described as being a physical, mental, and emotional (spiritual), illness.<sup>127</sup> Therefore, true recovery must include these three components.

Dr. Purvis concisely describes the recovery process as "substituting people for the substance ...".<sup>128</sup> How we societal "gate keepers" can assist in this recovery process is the thrust of this section of the paper.

Dr. Purvis further describes how this recovery process may be facilitated.

And what works is to use factual information to break the denial of the alcoholic. Get them to see that they are the problem; their behavior is the problem, and that their behavior in relation to booze is interfering in their lives and making their lives unmanageable ...

To help that person recognize that in reality he is part of the problem or his behavior is the problem and have the person, patient, client, however you want to define him, become involved in solution to the problem rather than being part of the problem and directing [his] energy to solving or being in the solution is the trick of the alcoholism counselor, treater, [or] facilitator. The trick is to get the person to direct [his] energy to being part of the solution rather than part of the problem.<sup>129</sup>

Recovery from the disease is principally an "inside job." By that, I mean the long-term process involves a substantial change being wrought in the individual. This change is, in fact, a result of

individual willingness. However, it can rarely be accomplished without substantial assistance from others. Dr. Purvis says, "all you have to do to recover from the disease is to QUIT drinking, and change your life 180°." Both these simple tasks are made possible by the assistance of others who care. A common saying in Alcoholics Anonymous is, "I get drunk, we stay sober."<sup>130</sup><sup>131</sup>

#### Short Term Treatment

Since the alcoholic almost always needs others to facilitate his recovery, this assistance can be broadly classified as treatment. Treatment for Alcoholism may take many forms and models. Appropriate treatment can be different for each alcoholic according to his needs. Although there is no single indicated protocol, there are identical basic underlying goals common to the more acceptable treatment procedures.

Dr. Zuska defines treatment for Alcoholism as follows:

Treatment for Alcoholism includes intervention, safe detoxication, overcoming denial, and amelioration of specific mental, physical and social problems by involving the patient in group counseling, education and exposure to a sound introduction to Alcoholics Anonymous. The goal is continued involvement in AA with the attainment of a drug and alcohol free life style that is comfortable and productive and a state of recovery that accepts one's powerlessness over ... [alcohol] use and includes willingness to accept help from others.

Treatment also includes involvement of the family and significant others in counseling, education and attendance at Al-Anon and Alateen meetings.

Aftercare is an important component of treatment and involves crisis backup and the availability of a support system to increase the gains made during treatment. Ideally, such aftercare should continue for a three year period.<sup>132</sup>

In treating the alcoholic for his disease, the first goal is to assist him in reaching his "bottom" or "moment of truth."<sup>133</sup> At the beginnings of Alcoholics Anonymous, in the late 1930's, the "old timers," were all "low bottom" drunks. That is, before recovery, most had reached

"skid row," eating out of garbage cans or begging money for a drink of red-eye. These "old timers" were, therefore, of the opinion that in order to recover, one first had to hit "bottom," like they had. The younger person with an alcohol problem was suspect, since he might not have done enough drinking to really be an alcoholic, in the old timers' eyes, and therefore, the AA program might not work for him. This syndrome has largely disappeared with time and experience. Now there are some eleven-and-twelve-year-old children who are in recovery, having reached their own particular "bottoms."<sup>134</sup> The "bottom" is that point of self-realization where the alcoholic decides that his life style is unacceptable, that this unacceptable life style is due to his or her dependence on alcohol, and that he or she is willing to change. The "collapse of the denial system"<sup>135</sup> is another term that describes this "bottom" appropriately. Treatment of the disease, therefore, involves, first, detoxification and minimizing the acute physical manifestations, such as seizures or Delirium Tremens (DTs).<sup>136</sup> Detoxification is usually accomplished through short-term hospitalization and very short-term use of tranquilizers such as Librium or Valium.<sup>137</sup> Such medication must be minimal and short lived since alcoholics tend to be cross-addictive.<sup>138</sup> This tendency is so well recognized that Alcoholism has been facetiously described, on occasion, as "a Valium deficiency."<sup>139</sup>

<sup>140</sup>  
Intervention can take place either before or after the Detoxification. No matter when it takes place, the purpose is to bring to fruition the collapse of the denial system. Resistance varies with the person. Detoxification is seldom sufficient on its own to bring about recognition of the bottom. Once the alcoholic is detoxified and starts feeling better, he tends to think he is cured, packs his bags,

and leaves the hospital, usually stopping off for a drink on the way home. I have known alcoholics who were detoxified over 30 times and kept on drinking. It is, therefore, important to get the sick but still denying alcoholic into a treatment program that works on the denial. Most disease concept treatment programs work, basically, on the same theory with some variations. The primary goal is a breakdown of the denial system. If that is accomplished, then the consequent acceptance of the disease and the beginnings of the trek towards recovery follow. As the recovery gets started and progresses, it is also important to assist in helping the recovering alcoholic to solve some of his other life problems. Personal support is an essential component as well.

Dr. Zuska uses a very effective technique for bringing the alcoholic through the bottom and "acceptance." He allows the alcoholic to make his own diagnosis. He explains,

I think it's good to let the patient make the diagnosis. Of course, here at St. Joseph's hospital, most of our patients we get, they're pretty late and the medical laboratory pages are full of evidence of Alcoholism, so we share that with them and sometimes they'll maintain their innocence. "I'm not alcoholic."

I say, "That's funny." And they say, "What do you mean, that's funny?" "Your liver is alcoholic. You and your liver ought to get into a conversation. You don't know each other."<sup>141</sup>

The good, in-patient, disease-concept, treatment programs are similar in content and emphasis. Doctor's Hospital, <sup>142</sup>CARP Unit, in San Diego, California, uses similar modalities and concentrates on pretty much the same goals as does Arlington Hospital <sup>143</sup>ATU in Arlington, Virginia. Such programs usually last for three to four weeks, sometimes longer. They concentrate on abstinence from alcohol, educating the alcoholic regarding his physical disease, breaking through his defenses, getting



him to know himself and accept himself in group therapy, and becoming part of the community of people with similar problems. Individual counseling is available, as needed, relaxation therapy, studies in alternative non-alcoholic life styles, and intensive exposure to Alcoholics Anonymous are also provided. Most programs involve certain control of movement and a programmed schedule to assist the alcoholic in not drinking, one day at a time. In many programs, Antabuse (Disulfiram) is also<sup>144</sup> used. Antabuse has no effect on the body except or until alcohol is ingested. When an alcoholic, who is on a regimen of Antabuse, drinks alcohol, he gets violently ill. Vomiting, rapid heart beat, and dizziness are among the unpleasant effects. This effect is caused by the chemical interfering with the body's ability to synthesize the alcohol and fully break it down into its ultimate, non-toxic, component parts. Because of the possible dramatic physical reactions, Antabuse must always be prescribed by a physician after the physician is satisfied with the physical well-being of the individual. If a person who had a substantial heart problem were to undergo an Antabuse reaction, it might be fatal.

The Alcoholism Rehabilitation Unit (now service) at the Naval Regional Medical Center, San Diego, California, is typical of this effective, disease-concept model. When Dr. Purvis was director of the<sup>145</sup> Unit, the usual length of treatment was six weeks. The patients lived in barracks-like facilities, no differentiation was made by rank or age. The wearing of uniforms was kept to a minimum. All patients referred to each other by first names. The counselors were also on a first name basis with patients. Only the director was referred to as "Doctor." Patients were restricted to the hospital grounds at all times for the first two weeks of treatment. After that required time period, weekend passes were allowed.

During the week, all patients had to be in the barracks by ten o'clock p.m. However, they were encouraged to talk with each other as late as they desired. This "sharing" was an essential part of the therapy.

The day started at approximately seven o'clock a.m. The patients arose, tended to personal needs, dressed, and breakfasted in time to be ready for 8:30 a.m. small group therapy. These daily sessions were facilitated by professional counselors who were tough-minded and frank. The patients were treated with frank, objective support, what is referred to as "tough love."<sup>146</sup> Obfuscation and avoidance were not tolerated. Many a small group session ended with some patients in tears brought on by anger and frustration. However, the patients gradually opened up and started to accept the fact of their disease.

At 10:00 a.m., the group generally broke for 15 minutes. At 10:15 a.m., a film or a lecture was scheduled. The subjects varied from "physical effects of alcohol on the body" to "living one day at a time" to "acceptance." After lunch, and a period of relaxation, organized physical exercise was scheduled. Sometimes, in the afternoon, lectures would be scheduled as well. Prior to dinner, an hour or so of free time was provided. After dinner, the entire group of patients would climb into vans and attend local Alcoholics Anonymous meetings. This schedule remained fairly constant with some individual counseling, as needed. In six weeks, a patient was released with a prognosis and a "survival plan." The prognoses varied, however, the "survival plan" always included Alcoholics Anonymous meetings and, in most cases, continued use of Antabuse.

Antabuse was prescribed for and taken by all patients at the Unit, and upon release, a 90 day supply was given to each person. This prescription was renewable.

This regimen is typical of most of the successful medical model programs.<sup>147</sup>

There are a variety of out-patient programs based on the same concepts. Some of these are very effective and, of course, are much less expensive than the in-house treatment programs.<sup>148</sup>

Other alternatives available in some areas are social model, non-medical, live-in programs.<sup>149</sup> These are usually a variation of the "halfway house" concept with counselors in-house.

The tenants may start in the house as non-working, very sick people, in early recovery, and progress to relatively healthy people, holding down full-time jobs and just sleeping at the facility at night.

All of these programs can be effective. It depends on what the individual alcoholic needs to help him get sober. As long as the orientation of the treatment program is toward a disease concept and Alcoholics Anonymous, it has a good chance of being beneficial. Of course, if a person is so sick that he needs the medical in-house treatment, then it would be ineffective to put him in a part-time, out-patient program. However, those judgements must be made in individual cases.

Dr. Puvis describes the essence of the treatment program as follows:

There are really four A's to the recovery process from alcoholism. Abstinence is absolutely required. That is the beginning. Alcoholics Anonymous is the next two A's; it works so well that it is at least

half; and Antabuse is Disulfiram, a medicine that is used to interfere with the impulsive drinker and the impulsive drink or the drink that comes from despair in the early stages of recovery. Long-term Disulfiram use is probably not useful, except in rare, very rare, instances.<sup>150</sup>

#### Long Term Treatment - Alcoholics Anonymous

Most of the literature and knowledgeable opinions today point to Alcoholics Anonymous as the ultimate treatment, or program of living,<sup>151</sup> for the recovering alcoholic. Whether an alcoholic needs more than Alcoholics Anonymous to start with is dependent on the individual and the circumstances. In Dr. Purvis' words:

I have found that even the alcoholic in full-blown DTs that does not go to a treatment facility and just sweats through his DTs with somebody holding his hand, either in a boxcar or a four dollar a night hotel room, can recover if he goes to Alcoholics Anonymous and has the ability to be honest and listen. Most people who recover from alcoholism get to the ability to listen when everything else that they tried didn't work.

I don't know what the right number is.. I know that for some people three meetings a week is all they need, and they don't need Antabuse and they don't need a psychiatrist and they don't need an alcohol treatment facility, and they don't need group therapy. They just go to AA and they get well.

And I know some people who need intensive hospitalization to treat the medical complications of their disease, and that they are terribly emotionally immature. They have a brutally devastated small self-esteem. Most of them are filled with self-loathing, self-hatred, because they made decisions about themselves as human beings while they were intoxicated and the brain wasn't working properly. It is these people who need to be involved in honest, caring and sharing environment, be it Alcoholics Anonymous, be it in a treatment facility, be it a prison, but in a place where they can see what the real self is. That's what recovery is all about.

So I don't know. I don't know what level of treatment is required for each person. I have an intuitive way of dealing with each patient, and I'm not always right. I do know when somebody's about to have a seizure, which we call "rum fits" or go into the DTs, I would prefer to have them in the hospital. Just that that's as much for

my comfort as it is for the patient's safety. [It is] easier to treat them in the hospital. It's easier to cover complications, but probably half of the people who have "rum fits" and have gone into the DTs today have done it outside of the hospital, ...<sup>152</sup>

Whether an alcoholic originally starts his recovery in Alcoholics Anonymous, joins AA while he is in other treatment, or joins AA after initial treatment, if he is going to stay sober, he will almost always maintain his sobriety through Alcoholics Anonymous.

In a recent book on Alcoholism treatment, Drs. Zuska and Pursch, who authored the seventh chapter, state:

There is no longer any doubt that Alcoholics Anonymous is responsible for the sobriety of more alcoholics than any other single treatment modality.<sup>153</sup>

The question arises, "What is Alcoholics Anonymous and how does it work? This is not an easy question. In the AA preamble, the organization is described:

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength, and hope with each other so that they may solve their common problem and help others to recover from Alcoholism.

The only requirement for membership is a desire to stop drinking ...<sup>154</sup>

Alcoholics Anonymous, as an organization, does not own real estate or other property and is singular in its stated purpose. It only solicits enough money to be self-sustaining, and then, only from members. It declines all outside contributions.

The meetings of Alcoholics Anonymous may vary in form and style; however, they are identical in purpose - to help alcoholics recover from Alcoholism. Some meetings are "discussion meetings." In these meetings, the chosen leader for that day suggests a topic related to recovery from the disease, such as "gratitude for recovery," "freedom from

compulsion to drink," or "benefits of the Program." The leader picks volunteers who wish to share their experiences with the topic, or the leader may choose people to share. The volunteers or selectees usually speak for less than five minutes, at which time the leader selects someone else. The meeting is usually one hour long.

Another form of meeting is the "speakers meeting." In this meeting, speakers, usually two in number, speak for one-half hour each. They usually tell the story of their experience with the disease; that is, what it was like when they were pathologically drinking, what kind of "bottom" they hit, and what life is like now.

A third format is the "California style meeting." This is really a compromise between the two others. Either volunteers or selectees are asked to walk up to the front of the room and share at a microphone for a short period of time, usually less than five minutes. Although this kind of a meeting is anxiety producing in the new member, it is also therapeutic, since speaking at the podium, into a microphone, is an effective way to get comfortable sharing with others; an essential for long-term recovery.

There are varieties of modified meetings as well, such as "women's meetings," "men's stag groups," or "open meetings" where non-alcoholics are welcome.

Most meetings last one hour or thereabouts. When a person goes to a meeting for the first time, he or she is usually overcome by the empathy, understanding, and the caring that he or she finds there. Most recovering alcoholics in AA look well; some are successful business persons or professionals, and others have blue collar jobs. Some are right off skid row, shaking and sweating, and two hours from their last

drink. Mutual acceptance and caring, one for the other, is the pervasive emotion one feels at an AA meeting. This acceptance and caring cuts across all social and professional strata because, although each person's story may be different, the feelings are all the same. One alcoholic feels the same emotions as another, and when the recovering alcoholic - bank president sees the shaking wino just off the bowery, his feeling is, "There, but for the grace of God, go I."<sup>155</sup> In truth, the difference between the two men is one drink and a finite amount of time for the progression of the disease to work.<sup>156</sup>

Judge Leon Emerson of the Los Angeles Municipal Court relates his feelings in attending an AA meeting as a guest:

I remember [the] first AA meeting I went to -  
... Chuck, who's been sober now for 18 years;  
Chuck, ... insisted that I go to his first year's  
birthday party.

... So I said, "Okay, I will." When it came about,  
I didn't want to. The wife didn't want me to, and  
so forth. But I did. It was 11:00 Sunday morning  
... he was going to receive his birthday cake. It  
was at the Paramount Womens Club here in Paramount  
[California].

I went down there and it was wall to wall people;  
about a third of them I knew. Now, not drinking  
buddies, but they were people from the country club,  
there were people from various and sundry organizations,  
political organizations, ... . God, my first  
meeting ... I was absolutely appalled. At first,  
they all welcomed me, and they thought I was coming  
for myself. Then when they discovered that I was  
just there for the education, they said, "Sure,  
happy to [have you here]. Chuck introduced me as the  
judge who sent him to AA, big applause ... made me  
feel great. And that went on, I remember it was  
11:00, and I said, "Chuck, this is great." I said,  
"when can we go to another AA meeting?" "Oh, There's  
one at 1:00." So we went to that one. I said, "Gee  
Is there another AA meeting around?" He said, "Hey,  
there's one at 8:00." So we went back to his house,  
and I called my wife and said, "I won't be home. I'm  
going to another AA meeting tonight." She says, "Be  
my guest." You know, she was mad at me by this time,  
would hardly speak. That night we went to an AA meeting,  
then we went to a hoot owl meeting. Really, the first  
24 hours we went to 4 meetings.<sup>157</sup>

Although most people do not attend four meetings on the first day they are introduced to AA, Judge Emerson's enthusiasm is typical of those experiencing an AA meeting for the first time. It is important to realize that there are many "open meetings" available in most areas. Attendance at a few of these meetings is highly recommended for all of us "helping" professionals. Our understanding of the disease can be markedly improved by making two or three AA meetings. As to availability of meetings, there are over 700 meetings per month in the Washington, D.C. metropolitan area; 300 in San Diego, California.<sup>158</sup> In almost every town of any size in the United States, there are at least three AA meetings per week. AA is international. In Paris, there is an English speaking meeting every day of the week, in addition to the many French speaking meetings.<sup>159</sup> AA is growing constantly and progressively. It is, in fact, the long-term treatment answer.

A word should be said about the personal growth aspect of AA membership and how, over a period of time, the recovering alcoholic matures and grows as he adopts the AA concepts into his way of life. Through AA, the recovering alcoholic not only stops drinking and is able to stay stopped, he is also able to improve the quality of his life. The compulsion to be able to drink like a "normal person" is replaced in the recovering alcoholic with an honest desire not to drink; total relief from a compulsion to drink and a positive attitude toward life without the need to drink. The recovering alcoholic in AA becomes grateful for the freedom from the need to drink rather than feeling self-pity because he cannot drink. The program for happy, successful recovery is embodied in what are known as the twelve steps of Alcoholics Anonymous.



#### THE TWELVE SUGGESTED STEPS\*

1. We admitted we were powerless over alcohol — that our lives had become unmanageable.
2. We came to believe that a power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understand Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and practice these principles in all our affairs.

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In applying these steps to his or her life, the alcoholic gains a freedom from the past guilt, and from the future fear. He or she becomes able to live in the present and be honest and forthright. As long as an honest attempt is made at living according to the steps, and attendance at meetings is maintained, the alcoholic can achieve permanent sobriety, one day at a time.

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The program of AA is a dynamic, progressive, positive, effective approach to the disease of Alcoholism. So effective is the program that several spinoffs are in existence. Among the most successful are: Narcotics Anonymous for the narcotics addicts, and Overeaters Anonymous for overeaters.

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Since Alcoholism is a family disease and we know that the "significant others" in the practicing alcoholic's life become ill as well as does the alcoholic, adjunctive organizations have been developed for their treatment. Al-Anon is an organization for spouses and close relatives of alcoholics, and Al-Ateen is a similar organization for teen-age "significant others" of the alcoholic. Both Al-anon and Al-ateen are based on the same fellowship and sharing principles that AA is based on. They also employ a slightly modified version of the twelve steps. These organizations are programs of personal recovery for the co-alcoholic<sup>162</sup> "significant others;" they are not designed to necessarily facilitate the alcoholic's recovery. If the co-alcoholic's recovery positively affects the alcoholic, that is a side benefit.

In all of these programs, it should be remembered that the steps are goals to work towards. For many, it takes years to finally work their way through all twelve. Some never do and die happy and sober as long as they are making an effort and don't drink. As it says in the book, Alcoholics Anonymous, in the first section of Chapter 5, "How it Works", "We claim spiritual progress rather than spiritual perfection."<sup>163</sup>

#### Other Long Term Treatment

Other counseling for the disease is recommended if it is used in conjunction with AA.<sup>164</sup>

Religious counseling and conversion, alone, have been successful on very few occasions in working a permanent recovery from the disease.<sup>165</sup> It is probable, however, that the few historical cases of "drunkards" being transformed or "cured" did in fact take place through a profound religious experience.<sup>166</sup>

Religious counseling, in conjunction with AA, is often very successful. In fact, many times the alcoholic begins to find the spiritual life in AA and then rejoins the church for his or her religious needs. Members of AA are always careful to say that AA is a spiritual program, but it is not religious.

Psychiatric counseling is useful in some cases. Once sober, about the same percentage of alcoholics need psychiatric help as do the rest of the population.<sup>167</sup> A good psychiatrist, who knows about the disease of Alcoholism and who does not give prescriptions for mind-altering drugs to the alcoholic, can be of great value in conjunction with the basic AA program.<sup>168</sup>

#### Alternative Treatment

Aversion therapy, LSD therapy, behavior modification, and other concepts have had some reported successes. However, none of these methods have had anywhere near the documented success rate that AA has enjoyed.<sup>169</sup> Therefore, in light of the evidence and the possible dangers involved in these alternative methods, it seems advisable to stay with the disease concept model coupled with AA, or with AA alone.

#### Should We Treat the Alcoholic?

The answer seems obvious. Of course! In times past, there was no question. Treat the alcoholic with the best therapy there is. Not only was it humanitarian, it was also dollar wise in most cases! Dr. Purvis says that things have changed:

It is no longer as economically feasible to treat ... the recovering alcoholic or the addict as it was 10 years ago. The statistics that were generated by the Navy and by McDonald-Douglas and the Bell System about how cost effective it was [no longer holds]... Now, it's still cost effective to treat an airline pilot who's tough to

replace. It's still cost effective to treat somebody with millions of dollars of training, but it is no longer cost effective to treat the new employee who's working at the minimum wage for Alcoholism. ...

The shame of that is that when it was cost effective, we had a lever. ... If we go in and we say it's only cost effective to treat somebody who's making \$25,000.00 a year, that's discrimination, and that would totally ... reduce credibility to zero. ... If you want to use cost effectiveness in treatment, it's very shaky now. ... The Navy sold a lot of their program on cost effectiveness. But when one doctor first treated the doctors, dentists, nurses, and MSC officers for five years, ... and had remarkable success, and then ... fighter pilots and aviators who have enormous amounts of training, and base statistics on that, of course, it's cost effective. You've got a million dollars invested in the training of a pilot, and you're going to lose him right at the peak of his productive career; it would be cost effective to put him in treatment for 6 months. But, [for] the Seaman Recruit or the person who's working for minimum wage or in job training, it is no longer cost effective, in my opinion, to treat him for Alcoholism, because the costs have now become prohibitive.

I've recognized that in corporations and in military organizations, social good is rarely a powerful argument. Money usually talks ... and mission is sometimes used as a lever, but social good is rarely a powerful argument.

To save lives and to stop the destruction of property [still] make sense to me. It makes economic sense to me.<sup>170</sup>

Considering the actual cost to the state and society of processing Richard (story in Introduction) through the system, it would still have been dollar wise to treat him early in the disease process and possibly prevent some of his incarceration.

Judge Emerson comments on the same vein regarding costs of in-patient treatment.

I think the hospitals have priced themselves out of the range of seven out of eight — it's seven, eight, nine, ten thousand dollars now<sup>171</sup> and I think we're going to have a rude awakening.<sup>171</sup>

It appears now that with the increase in costs of in-patient care combined with the new insurance policy directives removing Alcoholism Treatment from Blue Cross/Blue Shield coverage,<sup>172</sup> less in-patient treatment

will be available, and if available, less will be utilized. However, we all agree that the alcoholic must be treated.

It appears that the out-patient and social model rehabilitation centers will be utilized more and more. And of course, the doors of AA will always be open as well.

#### Pre-alcoholism and Screening Programs

The Federally funded civilian program, Alcohol Safety Action Program (ASAP) and the Navy Alcohol Safety Action Program (NASAP) are education and screening programs designed to prevent the potential alcoholic from developing the disease, through education, recognition, and the development of alternative modes of activity.<sup>173</sup> These programs also act as screening programs to steer sick alcoholics into treatment. These and similar programs are available in many jurisdictions as programs for education on diagnosing and referring clients who have alcohol related difficulties.

In many jurisdictions, there are other screening facilities and informational agencies for alcohol related problems. There are usually alcoholism counselors and referral agencies in most large towns and cities. Their telephone numbers usually appear in the telephone book white pages in the vicinity of the telephone number for Alcoholics Anonymous. As an example, there are twenty-six listed agencies dealing with Alcoholism treatment, counseling and screening the the Washington, D.C. telephone directory, not counting the listings under "U.S. Government." Information services, screening services, and referral services are available in virtually all jurisdictions. If a specific service is needed and it is not listed, a call to Alcoholics Anonymous central office for the area will secure the information if it is available.<sup>174</sup>

Practitioners should familiarize themselves with the specific services available in their own geographical areas. If such information is not readily available, through the phone book or word of mouth, call the telephone number listed for AA in the closest town large enough to have such a listing. Virtually all of the information regarding treatment, counseling, and recovery programs in the area will be available through local AA members.

#### The Lawyer's Role in Recovery

Since the lawyer is many times the first professional with whom the suffering alcoholic has contact, the attorney is many times the key person in facilitating his sobriety as well as defending him in court.

It is well recognized that voluntary intoxication is not usually a defense to a crime.<sup>175</sup> However, in some jurisdictions, substantial intoxication can negate requisite intent to commit a specific intent crime.<sup>176</sup> For example, if a person were accused of sabotage and was in a state of substantial intoxication, that level of intoxication, voluntary though it was, could be presented to show inability to harbor the specific intent of "Interfering with the defense of the United States."<sup>177</sup> Of course, the lesser included offense of "Damaging Government Property" would still be viable.<sup>178</sup>

Regarding the disease of Alcoholism, there are some interesting arguments to be made on voluntariness. If the disease of Alcoholism is contracted involuntarily and the compulsion to drink is part of the disease, at least in its last stages, then how can it be said that an active alcoholic drinks voluntarily or could be voluntarily intoxicated? He is compelled to drink by his disease. The weak link in the argument

is the ~~cause-of-the-disease~~ concept. It is true that we do not know what causes Alcoholism, but it is also true that if a potential alcoholic never drinks alcohol, he never becomes an alcoholic.<sup>179</sup> The first cause then is voluntary. Such arguments are interesting but approach the philosophical abstraction of attempting to determine how many angels can dance on the head of a pin.

The practical effect of such a defense might also be destructive since a large part of the recovery process is an "inside job." The individual must take responsibility for his own actions. This practical consideration cuts against the "Alcoholism Defense."

Since the focus of this paper is understanding the disease of Alcoholism and, in this section, the role of the lawyer in the recovery process, I shall leave further discussion of alcohol intoxication and alcoholism as defenses on the merits to other authors who have written copiously on that subject.<sup>180</sup>

Despite the fact that acute alcohol intoxication or Alcoholism are not generally defenses, they are valuable as matters to be raised in extenuation and mitigation. In some jurisdictions, where the proceeding is unified, that is where the case on the merits and on sentencing are tried at the same time, the Alcoholism issue may be argued once, with the result that it usually fails on the issue of guilt or innocence, but succeeds beautifully as a primary matter in extenuation or mitigation on sentencing. If, in your jurisdiction, the proceedings are bifurcated, with separate hearings on the merits and sentencing, then you can choose your time and place to bring up the Alcoholism. Often a contrite guilty plea, followed by a strong presentation speaking to the defendant's Alcoholism and his recovery program, brings a most satisfactory result. If the criminal act can be linked to the untreated Alcoholism and the Alcoholism can be shown to be under treatment at the time of the hearing,

the sentencing body can, and will, feel comfortable in awarding a light sentence, generally designed not to interfere with the defendant's recovery.<sup>181</sup> I have used this technique in several cases myself. I learned about it from a client of mine and a very savvy military judge in Charleston, South Carolina.

My client was an older senior petty officer, who had been an Unauthorized Absentee for a relatively long period of time. When he said that he was in AA and had just received a Blue Chip,<sup>182</sup> signifying 30 days without a drink, I was not terribly impressed. However, after his testimony on the stand in which he related his involvement in AA, I was very impressed, since the judge awarded him a very light sentence, which did not include confinement. As a parting comment, the judge smiled and told him to "Go home and have a milk-shake."<sup>183</sup>

<sup>184</sup>  
Attorney Lee Estep of San Diego, California explains his use of "recovering alcoholic" mitigation this way:

Let's take David who I met out at the Veterans' Administration some 6 months ago, who had his 8th drunk driving offense. He was obviously going to spend a year in honor camp. He voluntarily submitted himself to the V.A. hospital. I first met him after his 4th day in the hospital, still shaking and hadn't had a sober breath for many years. He has eight children, a lovely wife, a Mexican girl, and I started talking to David and took his case pro bono to represent him out in the El Cajon Court. It was my condition that I would represent him if he would make one AA meeting per day until such time as we came in for sentencing, which was 6 months later.

After he got out of the hospital, he kept doing that, and he recorded this on paper, just listing one through thirty, [as] he would go to the meetings.

When we went into court ... yesterday, we were able to point out to Judge Howlett the fact that this man had six months of sobriety, six continuous months, only missing 5 AA meetings, five days of AA meetings. The probation officer had recommended one year in the County Jail. Judge Howlett said, "If this man can do this, based on AA, if AA is working for a man who hasn't been sober in 20 years, his wife comes up here



and says he's now sober, I can't do anything else but put him on probation. So I'm going to put him on a year's probation based on the fact that he continue at least the minimum of once per week or 52 meetings per year in AA." Now that's pretty good.<sup>185</sup>

The City of Alexandria, Virginia, prosecutor, Drew Carroll,<sup>186</sup> puts great importance to having an AA sponsor in court with the defendant. He considers AA sponsorship a viable alternative to incarceration for the alcoholic. He emphasizes however, that there must be a reasonable survival and recovery plan submitted before he will recommend an alternative sentence in most cases.<sup>187</sup>

The lawyer who is sensitive to the presence of the disease in his clients, who knows about the recovery process, and who has investigated the screening, diagnostic, and treatment facilities in his particular area can become a fulcrum in lifting his suffering alcoholic clients from living death to a life of happiness and fulfillment. This beneficial action fortunately runs parallel and almost never conflicts with doing his legal duty and getting the best for his client. It is certainly more comfortable to represent, in court, a recovering alcoholic with bright eyes and a sense of health about him than it is to walk before the bench with a lying, coniving, conning, shaking, hostile, practicing alcoholic who will likely turn on you if you are foolish enough to put him on the stand.

When that sick alcoholic walks into the office, we have the leverage: We should use it! Not only will he fare better as a client, but with our assistance, he may start his recovery.

#### The Judge's Role in Recovery

The Judge can do more to facilitate the recovery of the alcoholic defendant than anyone else in the system. Once he identifies the alcoholic

before him, he can fashion a sentence to appropriately assist the alcoholic in starting his recovery. The famous lecturer on Alcoholism, Father Martin, says in the motion picture, "Chalk Talk" <sup>188</sup> regarding helping the alcoholic, "You can lead a horse to water, and you can't make him drink, but you can make him thirsty."

The Judge has the power to help the alcoholic get that "thirst" for sobriety, partly through counseling from the bench, but most of all through the specific sentence he gives.

One of the old timers in AA in Northern Virginia explains that he was induced to go to AA when the Judge gave him a chance of staying in jail, going to Western State Hospital for the Insane, or going to AA under the sponsorship of a particularly well respected recovering alcoholic who had volunteered. Being typically savvy, the defendant chose to go to AA, just to stay out of jail or the insane asylum. That was 16 years ago. The then defendant has not had a drink since then nor has he been a defendant in any subsequent criminal proceedings. (He had been arrested twenty-five times in the year prior to this pivotal incident.) This man is now a pillar of the community and has virtually dedicated his life to helping other alcoholics. Such results are possible if the judge understands the disease, recognizes the disease, and sentences with recovery from the disease in mind.

As previously discussed, the concept that the alcoholic cannot <sup>189</sup> be helped until he asks for help has been largely disproven. The U.S. Navy has been ordering officers and sailors to treatment for more than <sup>190</sup> 10 years. The success rate has been extraordinary. Statistics regarding alcohol recovery are subject to such subjective benchmarks that reduction to percentages of recovery is difficult; however, in a 1978 study on alcoholics who had been treated by the Navy;

Supervisors reported on drinking patterns indicates that 78% were abstinent and 92% were abstinent and/or drinking infrequently one year after treatment.<sup>191</sup>

The Navy experience has shown definitively that coerced treatment does work. Of course, the alcoholic must do the accepting of his disease and make his decision for sobriety, but he can be assisted in these decisions by coerced treatment.

As the successes of the Navy and other services have become recognized in the field of Alcohol Rehabilitation, the movement toward coerced treatment is spreading to the civilian sector. In an excellent article, titled Voluntary v. Involuntary Treatment of Alcoholism, appearing in the April 1982 edition of the Florida Bar Journal, Administrative Law Judge, Michen E. Hanrahan acutely observes that voluntary treatment is an unrealistic concept, since no one enters treatment without some reason. He explains;

No one abusing alcohol suddenly awakens one morning and says, "It's a nice day, I think I'll put myself in Treatment." Coercion is always applied in varying degrees by a spouse, a physician, or clergyman, and with increasing frequency, a boss.<sup>192</sup>

The real issue is, then, should the alcoholic be coerced from the bench? With few exceptions, practical thinking judges answer this question in the affirmative.<sup>193</sup> According to Judge Hanrahan, under the Myer Act, Florida put some meat on the bones of the Federal Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, when it made provision for the filing of a petition in the court for treatment of an alcoholic by a spouse, next-of-kin, guardian, and others. Judge Hanrahan says that the Act is not used extensively however.<sup>194</sup>

Compulsary treatment for alcoholics and addicts has been approved by legislation in Ontario, Canada. The bill is unique in that it<sup>195</sup>

allows police to detain alcoholics and addicts in treatment centers without benefit of judicial decree. As one could imagine, there is substantial dissent and unrest among the Canadian Civil Liberties Association. The eventual fate of the law has yet to be determined.

Despite the statutory framework, or lack thereof, regarding court-ordered or compulsory treatment for Alcoholism, many knowledgeable judges have been facilitating alcoholic recovery for years. Perhaps, the most successful and one of the most famous of these judges assisting in alcoholic recovery is Judge Leon Emerson of the Municipal Court, County of Los Angeles, California. Judge Emerson describes his system:

I think what I started here 15 years ago ...  
enforced treatment. Using the criminal justice system  
and the court card was not necessarily new but it was  
... [effective].<sup>198</sup>

Judge Emerson explains his treatment plans for the defendants that come before him who have been found guilty of alcohol related offenses;

First is the social drinker. He just gets a 32 hour class. And then the problem drinker or social alcoholic. The problem drinker gets the school, gets AA, gets a counselor once a week. And then I have the chronic alcoholic. The third category is the guy that may be on probation for up to two years, and he gets AA every night or maybe twice a week. He may be taking Antabuse. We do intensive social work on the third category.

The fourth category [the real physically sick person], I have to start him out in the program with 90 days in jail just to get him sober so that he can get to the point where he can actually understand what's coming down; and then he would be put into a school program, AA; I may stay with this guy five years.

I have the chronic alcoholic and the social alcoholic report to me about every three months. I want to make sure they continue to go their AA meetings. If they don't, it's sudden jail.

I want to make sure that the counselor's doing his job. He must report to me how many meetings a person's attended, group counseling, what his attitude has been, how he's getting along, what his lifestyle changes have been. Has the

guy [received] any promotions, has he gotten a divorce; what's happened with [his] life ... I've got it boiled down to one simple sheet which categorizes these things, [they] give me the numbers, and these numbers tell me ... what this person's doing.

Every three months, if he's on probation, with the probation department, the probation officer has to make these reports, and they hate me because they make so many more reports to me than they would to any other Judge.<sup>199</sup>

Judge Emerson instituted a card system to keep track of the defendant's attendance at AA meetings. The card is reprinted below:

<p><b>VIOLATION</b> _____</p> <p><b>CASE NO.</b> _____ <b>B.A.C.</b> _____ %</p> <p>_____</p> <p style="text-align: center;"><b>NAME</b></p> <p>_____</p> <p style="text-align: center;"><b>STREET ADDRESS</b></p> <p>_____</p> <p><b>CITY</b> _____ <b>STATE</b> _____ <b>ZIP CODE</b> _____</p> <p style="text-align: center;"><b>FOLD HERE</b></p> <p style="text-align: center; margin-top: 20px;"><b>I HEREBY CERTIFY THAT I ATTENDED ALL THE AA MEETINGS CLEAN, SOBER AND STAYED THE FULL MEETING.</b></p> <p style="text-align: center;">_____</p> <p style="text-align: center;"><b>SIGNATURE</b></p> <p style="text-align: center;"><b>AT PRESCRIBED INTERVALS OR BEFORE</b></p> <p style="text-align: center;">_____</p> <p style="text-align: center;"><b>DATE</b> _____ <b>AS ORDERED.</b></p>	<p><b>I HEREBY CERTIFY AS A SECRETARY OF AN AA MEETING, THE BEARER HAS ATTENDED A REGULAR MEETING OF ALCOHOLICS ANONYMOUS SOBER AND STAYED THE FULL MEETING.</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">DATE</th> <th style="width: 30%;">GROUP</th> <th style="width: 40%;">SECT'Y.</th> </tr> </thead> <tbody> <tr><td>1</td><td>_____</td><td>_____</td></tr> <tr><td>2</td><td>_____</td><td>_____</td></tr> <tr><td>3</td><td>_____</td><td>_____</td></tr> <tr><td>4</td><td>_____</td><td>_____</td></tr> <tr><td>5</td><td>_____</td><td>_____</td></tr> <tr><td>6</td><td>_____</td><td>_____</td></tr> <tr><td>7</td><td>_____</td><td>_____</td></tr> <tr><td>8</td><td>_____</td><td>_____</td></tr> <tr><td>9</td><td>_____</td><td>_____</td></tr> <tr><td>10</td><td>_____</td><td>_____</td></tr> <tr><td>11</td><td>_____</td><td>_____</td></tr> <tr><td>12</td><td>_____</td><td>_____</td></tr> <tr><td>13</td><td>_____</td><td>_____</td></tr> <tr><td>14</td><td>_____</td><td>_____</td></tr> <tr><td>15</td><td>_____</td><td>_____</td></tr> </tbody> </table>	DATE	GROUP	SECT'Y.	1	_____	_____	2	_____	_____	3	_____	_____	4	_____	_____	5	_____	_____	6	_____	_____	7	_____	_____	8	_____	_____	9	_____	_____	10	_____	_____	11	_____	_____	12	_____	_____	13	_____	_____	14	_____	_____	15	_____	_____
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The card becomes an integral part of the defendant's recovery plan. Judge Emerson explains:

And in the meantime, the guy brings me his cards, or takes them to his counselor, or he takes them to this probation officer or both ... when he comes into court, ... the counselor or probation officer's detailing him, and watching his cards and so forth.

I'll say, "Let me see your card." If he doesn't have his card, then I get on his case, because I know that card has to be part of it after a while.

I may ask him some questions about how he's doing in AA, where his home meeting is, and if I think he's been sluffing off, I'll say, "Okay, I want a fourth step ...

You've got to have positive control and you've got to make these people do what they need to do, and they're resistive as hell, but when I make 'em do a fourth step, then I make sure that they get an AA sponsor.

When I put them in violation, they are treated exactly like they would if they were in violation of a formal probation order. They get full due process of law. They are arraigned on the violation, they admit the violations. It's usually sudden jail of three days. If they deny the violations, it's set down for hearing in ten days, and they bring in their alcoholism counselor.<sup>200</sup>

Judge Emerson's program has been extremely successful for many years. His expertise in the field of Alcoholism and his fine, caring work on the bench, have brought him accolades from his peers and other professionals from far and near. Judge Emerson gave a major address at the International Conference of Alcoholics Anonymous, held in New Orleans, Louisiana, in 1980. In his address, he spoke about the criminal justice system as related to Alcoholism.

When I asked Judge Emerson why he was so successful in helping alcoholics get better when others were not so successful, he told me about a psychologist friend of his who had studied him on the bench to try to find the answer to that same question. The psychologist's answer was:

It's very simple. You don't hate the s. o. b.s, and they know it. You don't appear hostile to the alcoholic. The fact that he's an alcoholic, you just say 'so what, now, let's do something about it!'<sup>201</sup>

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Judge William Beard of the El Cajon Unified Court, El Cajon, California, has devised his own system for sentencing alcoholics.

Judge Beard explains:

I would judge that we have, of course, close to 70% of our cases directly involve alcohol. It makes no difference whether we have extensive therapy for the person who is in the criminal justice system or whether they get to AA or some other type of therapy.

We are basically in a position as judges to do more than any other individual to get a person back into the social responsibility.

One thing that most people that work in the field of alcoholism agree to, that regardless of how a person gets to recovery, whether it's through coercion through the courts, or coercion through his family or his employer, the main thing is to get him there, take that horse to the water. With that in mind, knowing that it makes relatively no difference in the rate of recidivism, those who voluntarily go to recovery, or those who are sent there under coercion, we, as judges, are in a position to really make a person attend.

I would like to have the [funding] in my court to send every one of them to an alcoholism treatment center such as the Navy has, at Naval Alcoholism Recovery, or even the NASAP program, but our people don't have [access to] that; ... And the only viable alternative is AA, because there is no requirement for membership fees, and so with this in mind, the El Cajon Court, a year and a half ago, inaugurated what is called a 90 and 90 program. We look at persons, basically drunk drivers, but they can be child molesters, they can be persons who fail to provide under [California] Penal Code Section 278, people who assault police officers, disturbing the peace cases, plain drunk, multiple check recidivist. These are the type of people who are alcoholic.

You can look down and I think a survey of our 90 and 90 program will show that the average person who is sent to 90 meetings of AA in 90 days has at least five prior involvements with courts that directly or indirectly involve alcohol. A great many of them, probably one-third of them, have already served substantial time in jail. I mean 90 days or more, and they are still recidivists.

Now with that in mind, I think we're going to get a fair sample of the cross-section of the population that has been having trouble with alcohol. At least, we'd get the same sample as any doctor or any hospital, any psychologist or alcoholism counselor would have. We are dealing with basically the same type of person.

Not all of our people go to 90-90. They have five encounters with the court prior to being sent, but if we see someone with a .20 or above, with not necessarily any priors, but maybe with a divorce in the family or some other objective symptomology, we will refer them directly to 90 and 90 program.

Now, I insist that most of them, if they're physically able to, get a medical exam. Take Antabuse ...

... the first numbers that I used, I did not use Antabuse. I had no control numbers on that, and I found that I was missing a few of them simply by not insisting on Antabuse.

I would venture to say 70% of those who complete the 90 and 90, at least, will never be in the criminal justice system, [again] but that's only conjecture. I have no statistics yet to establish this. We are going to continue to run statistics and in four or five years, we'll have something definitive, but the initial readings are just beyond all expectations.<sup>203</sup>

Judge Beard's program also involves the use of an attendance card. His 90 and 90 system is usually applied as an alternative to 180 days in jail. He explains his in-court approach:

We can -- we hold that over a person's head, that 180 days. "Now, you know what your punishment was. I'll give you an option. I think you're a sick man as well as being criminal. You go to 90 meetings in 90 days, and come back here 100 days from now, show me that you want sobriety, and I'm not going to send you to jail for that 180 days. But, if you go into this program, when you goof and go out and get drunk again, I'm going to give you 180 days, or if you fail to show up and complete it, I'm just going to assume that you are out drinking. If you don't show up I'm going to count you an automatic miss."<sup>204</sup>

Judge Beard maintains the integrity of his system by following through on his original agreement. This action not only maintains the judge's judicial integrity, but also is therapeutically appropriate, since the alcoholic must be held responsible for his own actions.

Judge Beard continues:

Now, I had one guy come in and obviously forged his attendance. I asked the prosecutor to investigate it ... The guy fessed up. He had his attorney, he had his constitutional rights, but I said, 'In order to have integrity, I told you what I was going to do. ... You admitted that you didn't attend these meetings. You're going to get your 180 days just like I promised you.' And that's what I did. Otherwise the system isn't worth a damn. You have to follow through.<sup>205</sup>

Although Judges Emerson and Beard are unusual in their methods, they are not unique in their goals. Most judges I have talked to and



practiced before are aware of the disease concept of Alcoholism and want to help. Unfortunately, however, most don't know how to help and many are under the outdated impression that an alcoholic cannot be helped unless he is ready, and asks for help.

Recently, I had occasion to discuss the interface of AA with the criminal justice system and corrections with a Northern Virginia judge. <sup>206</sup> He was 100% behind AA and thought it should be available in all the jails. He also gave titular recognition to the disease concept of Alcoholism. However, when I suggested sentencing with a view toward treatment and rehabilitation, he eschewed such an idea, suggesting Constitutional problems and the old saying, "can't help the alcoholic until he wants help." When I told him about Judge Emerson's and Judge Beard's programs, he was at a loss for comment. Judge Emerson has never had a constitutional attack on his program. Judge Beard did not mention any attacks at all.

I hope that the more staid members of the judiciary will see the value of the Emerson/Beard approach and join the enlightened judicial vein of sentencing with rehabilitation in view.

#### The Post-Trial Professional's Role in Recovery

Although each of these enumerated professions has a somewhat different function regarding the facilitation of potential recovery for alcoholics, these functions can be similarly categorized. Their role in helping the sentenced alcoholic into recovery is, in a word, essential. Nowhere else in the criminal justice chain can as much individual contact and observation be accomplished as in this last sector. In the case of the alcoholic, the now out of fashion, but still viable goal of corrections, rehabilitation, can be accomplished with great effectiveness. I have

often heard physicians who treat alcoholics say that theirs is a singularly satisfying practice because they see people who are so sick get so well in a relatively short period of time. <sup>207</sup> The post-conviction professions can get some of that personal satisfaction in their practice as well, if they get involved in the recovery of the alcoholic convict.

#### Incarcerated Alcoholics

Most knowledgeable professionals agree that treating the alcoholic who is incarcerated is a desirable thing. This goal is not without difficulties however. Judge Emerson points out the principal problem:

So the prison authorities, of course, [when] they see the person they may have his jacket which may be an inch thick. They're in the business of control, and they're in the business of controlling a very volatile population, and the common drunk is the lowest man on the social scale in the prison population. He gets least of the services, least jobs, least attention from the counselors. Consequently, ... it's going to be very difficult to get criminologists, professional criminologists excited about treating alcoholism. Maybe in another generation, yes, but I don't see it in the present political spectrum as we have [it] and the spectrum of the criminal justice system.

Like the Sheriff ... one time told me, he said, "Judge, we're not in the business of treating alcoholics, we're in the business of housing drunks." <sup>208</sup>

The corrections people are not to blame for this state of attitude. They are usually given too much to do with too few people and the result is warehousing. Exceptions to this rule do exist; however, the in-house treatment programs are many times more viable on paper than in actuality.

Setting up effective medical model, or social model, facilities in prison is expensive in dollars and manpower. However, the inmate is possibly at his closest to accepting his disease at this time. Dr. Purvis says:

The alcoholic that is incarcerated has an opportunity to, one, feel sorry for himself, resent the fact that he got caught and is incarcerated, or [two] adjust to the [prison]

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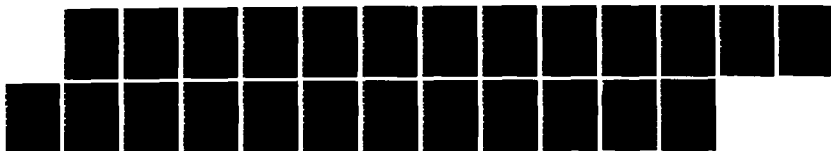
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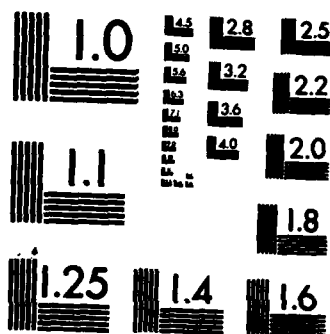
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environment, live that through so he can still have some energy when he is released, or three, effect some change. We are now asking the alcoholic who is incarcerated to effect change while in the prison system that people can't effect on their own on the outside, and some can't even effect while they're hospitalized for six weeks in an alcohol treatment facility.

What my question is, if they're there, let's do something with them. The statistics that I hear from the physicians and the wardens who run prisons is that the vast majority of the people who are incarcerated are there because of drug [including alcohol] related activity. If we remove chemicals from their life and can demonstrate that living without chemical for them would be more fun, and they would enjoy life or experience life in greater magnitude, then they might consider changing how they live.<sup>209</sup>

Since prison is an ideal place to start the recovery process, but it is highly unlikely that effective in-house programs will be available, then the reasonable alternative is in-prison AA meetings.

Dr. Purvis suggests:

... nobody has ever been hurt by going to AA meetings. And if I were to design a prison system of education, the people would be hearing about the principles of AA and the recovery part, all of the time.

... and the ones that complained about it would be the ones that didn't hear. ... now, if you're going to be in prison, you may as well have some fun and enlightenment, and do the things that help. So I would say the solution of the alcoholic person who is in the penal system is to make sure that [he goes] ... to AA.<sup>210</sup>

There is a special committee of AA, called the Hospital and Institution Committee, that takes meetings into jails and hospitals. Many recovering alcoholics started their recovery process in jail through the AA meetings. AA General Services has published several pamphlets dealing with the incarcerated alcoholic, and the AA periodical, Grapevine, occasionally devotes an entire issue to AA in prisons; July 1981 was the last such issue.<sup>211</sup>  
<sup>212</sup>

On February 21, 1982, I attended a conference titled "Carrying the Message to Alcoholics in Prison."<sup>213</sup> Panel members included ex-convicts

who had found AA and sobriety in prison, social workers who had worked with the ex-convicts, prosecuting and defending attorneys, judges, and corrections, probation, and parole officers.

The thrust of the entire conference was cooperation and awareness of the importance of the in-house prison AA programs. Several judges who were otherwise inadequately informed regarding Alcoholism were very supportive of the AA program in prison.

It appears, then, that considering the expense involved in setting up treatment programs and the relative austerity of municipal budgets, the incarcerated alcoholic will have to depend on the institutional AA and an understanding and knowledgeable corrections staff to facilitate his recovery. The prisons can facilitate recovery with such a program.

Judge Emerson tells the story of a penological pioneer and institutional AA below:

Many years ago there was an enlightened prison warden up at San Quentin called Warden Duffy, probably one of the outstanding criminologists in the United States. ... My good friend went to prison behind armed robbery, 11 armed robberies, and when he checked into prison, his first conversation with the warden was, 'But you're a drunk, your problem is you're an alcoholic. Why don't you look at your alcoholism while you're here.'

... He thought, 'Poo-poo.' He's a tough guy, he was an ex-cop, all of these things. He knew — he'd been to prison before, he knew all the songs to play, and all the games to play and so forth.

... He went to his first AA meeting a couple of years later to get a free doughnut and a cup of coffee because he'd heard they[had] doughnuts over there, and he'd like a doughnut.

[He] found the Book on AA, stole his first copy, took it back to his cell and read it that night. Well, he knew immediately what was wrong with him, but Duffy, Warden Duffy had told him when he first entered prison what was wrong with him. He wouldn't believe Warden Duffy. He credits Warden Duffy now for his sobriety and he is now something like 25 years [sober]. But these things happen. That's an unusual situation. Warden Duffy is, you know, one of the unsung heroes of criminology in the United States.<sup>214</sup>

It is in everyone's best interest if the corrections officer cooperates with the AA institutional committee regarding setting up meetings in prison. If the local AA chapter does not offer to set up a meeting, the corrections officer could contact the closest AA central office. The institutional committee will certainly do the rest. It costs the prison nothing in fees or outside costs, and the rehabilitative changes it can bring about in the prison population is astounding.

It may seem unnecessary to treat an alcoholic when he is in prison and does not have access to alcohol. However, even if he has no access, which is probably not the case, his disease stays active unless treated. If an alcoholic stops drinking for five years and then starts again, he will be just as sick as he was when he quit and probably do the same, or worse, things than he did previously.<sup>215</sup> So it is, with the untreated alcoholic in prison. He may not drink to excess while he is in prison, but when he gets out, he will celebrate by getting drunk. His activity while drunk will probably be criminal and there you have a recidivist back in jail again.

On the other hand, if he starts recovery and maintains his abstinence and AA program when he leaves prison, the chances are very slight that he will return. The answer is, then, in-house AA and support from the corrections staff.

#### Alcoholics on Probation or Parole

The alcoholic on parole or probation is probably in the best possible position to get into recovery if the sentencing official and the probation or parole officers are knowledgeable regarding the disease. As was discussed earlier in the Emerson/Beard sentencing concepts, mandatory attendance at regular AA meetings can be required. The parolee/

probationer can be required to get certified attendance checks on his card. He can also be required to get an AA sponsor.

If there are other community treatment services, he can be required to attend these as well. Regular monitoring, with a view towards how well the parolee/probationer maintains his sobriety, can be effectively maintained by his probation/parole officer. The parole/probation officer should be knowledgeable about the disease and be supportive of the alcoholic's survival plan. Since abstinence from alcohol should always be a condition of parole or probation for any alcoholic, any consumption of alcohol could be grounds for quick and sure retortion by the parole/probation officer. It may not be necessary to revoke parole or probation if the alcoholic slips once, but he can be threatened with such action and made to feel the presence of the "Sword of Damacles." If he drinks again, then the parole/probation revocation hearing should be fast and sure. Being responsible for his own actions is essential for the alcoholic's long-term survival.

A good probation/parole officer who is knowledgeable about the disease can do much in cooperating with AA and other community agencies to help the alcoholic convict get into recovery and remain sober. Incarceration and parole/probation have saved many alcoholic's lives when properly applied and adapted. With the information supplied in this paper, the post-conviction professionals can make sure that they are part of the recovery process.



## PART V CONCLUSION

I have presented a great deal of practical information about Alcoholism in this paper. Because I am a lawyer who has spent most of his time doing criminal law in the Navy, the information is focused for the use of the criminal lawyer. Much of the information has come from practical men of great expertise in their particular disciplines. My research technique was largely personal interview. A substantial portion of the tactical ideas and techniques recommended for dealing with the alcoholic client are original as I developed them over an appreciable period of time in handling approximately 2500 criminal cases. I am convinced that the practitioners of the legal profession, who digest this information and practice the techniques, will become better lawyers and more helping human beings.

This disease of Alcoholism is as old as mankind and as complex as any disease process known. We are just now beginning to understand its biochemical aspects, the genetic input, and the range of the emotional component. Just within the last forty years, we have discovered a treatment procedure that is effective in arresting the process. The reader might ask, "What next?"

I asked that very same question of some of the highpowered experts that I interviewed. To the man, they said the next stage is education of society regarding the disease. The physicians, Drs. Purvis and Zuska, believe that along with education will come prevention through early

detection of alcoholic tendencies and teaching responsible drinking or abstinence from drinking, whichever is indicated. This is a largely uncharted sea as yet. However, we can expect much discovery in the near future.

As with any complex disease or social problem, we should always look for the remedy, but beware of the overly simplistic quick-fix solution. As an example, I refer to the present mania regarding drunken driving and getting the drunk driver off the road. I am in absolute accord with doing everything possible to get the drunk driver off the road, but taking his license away won't do it, because he'll drive anyway; putting him in jail will merely delay his next drunken accident. The societal outcry for getting the drunk driver off the road stops one step short of the solution. Most of the drunk drivers on the road have a well developed case of Alcoholism. Doesn't it make sense to get the drunk driver off the road and treat him for his disease so that when he next drives a car, he will be sober? Surely, here is an area in which society needs education. As we assimilate more information about Alcoholism and increase our understanding of the disease, more effective programs will be developed and fewer short-sighted, quick solutions will be treated as the ultimate answer.

In our professional and personal lives, let us do our best to educate our fellow lawyers, judges, and post-conviction professionals regarding this devastating disease. The problem is so big, so misunderstood, and the possibilities of recovery from the disease are so great that our efforts to inform and educate can make an important and beneficial impact on society.

No man is an Island, entire of it self; every  
man is a piece of the Continent, a part of the

main, if a clod be washed away by the sea, Europe  
is the less, as well as if a promontory were,  
as well as if a manor of thy friends or of  
thine own were; any man's death diminishes me,  
because I am involved in Mankind; And therefore,  
never send to know for whom the bell tolls; It  
tolls for thee.

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## FOOTNOTES

<sup>1</sup> A term used by Dr. Gene Purvis in a presentation he and I gave on Alcoholism at the Navy Judge Advocate General's conference in 1979. The term describes the "helping professions" i.e., physicians, lawyers, etc.

<sup>2</sup> Commonly referred to as "Wet Brain." The Brain Function is permanently damaged. Many such alcoholics are permanently institutionalized. In the extreme manifestations, they lose control of bodily functions and seem not to know about their surroundings. Interviews with Dr. Purvis - 1976 through 1982.

<sup>3</sup> or Korsakoff's Psychosis; severe impairment of memory and learning. Islands of memory exist but they may be out of order with reality. American Medical Association Manual on Alcoholism (1972).

<sup>4</sup> (Laennec's Cirrhosis) Liver damage to the point where eventually death usually results from hepatic failure, hemorrhage, thrombosis, or infections. The body retains fluid to an extraordinary degree. Discomfort is constant. Personal observation of, and conversations with, several alcoholics suffering from this condition. Also - American Medical Association, Manual on Alcoholism (1972).

<sup>5</sup> In keeping with the tradition of Anonymity in Alcoholics Anonymous; Richard W. chooses to maintain his anonymity. However, if he can be of assistance to any individual in his or her recovery, he has assured me that he will break his anonymity on an individual basis and help as best he can.

<sup>6</sup> The Arlington Hospital Alcoholism Treatment Unit (ATU), Arlington, Virginia.

<sup>7</sup> "Picking up the phone" is a term used in AA, meaning to pick up the phone and call another member of AA to keep in touch and share. This contact with another recovering alcoholic has therapeutic value in much the same way sharing at an AA meeting helps. If you can't make a meeting on a particular day, the "old timers" in AA recommend making a call.

<sup>8</sup> Interview with Richard W. in Alexandria, Virginia (December 19, 1981).

<sup>9</sup> Isaiah 28: 1,3

<sup>10</sup> American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (Second Edition) (1976).

11 Common Societal religious view through the 1950s.

12 Referred to as a "condition" in motion picture, "Father's Delicate Condition."

13 American Medical Association, Manual on Alcoholism (1972)

14 I Corinthians 5: 11

15 Dr. Joseph John Zuska, M.D., Director, Recovery services, St. Joseph Hospital, Orange, California: Retired Navy physician, Board certified surgeon, co-founder of the original Navy Alcoholism Rehabilitation Service at Long Beach Naval Hospital, Long Beach, California. Dr. Zuska is a member of many professional societies. Among them are:

- \*Fellow, American College of Surgeons
- \*Immediate Past President, American Medical Society on Alcoholism
- \*Advisory Board, National Council on Alcoholism
- \*Member, California Society for the Treatment of Alcoholism and other Drug Dependencies
- \*Member, Association of Labor-Management Administrators and Consultants on Alcoholism

Dr. Zuska has written widely in the field of Alcoholism. Among his published articles are:

- \*Experiences with an Alcoholic Rehabilitation Clinic. U.S. Navy Medical News Letter, Vol. 52, No. 9: 1-3, November, 1968
- \*Alcoholic Education and Rehabilitation (Delivered to the Surgeon Generals' Conference, Washington, D.C., 22 May 1970)
- \*Defense Department Policy on Alcoholism (participated as consultant, 1972)
- \*Alcoholism in the Coastal Health Services Region Reported in February 1974
- \*Admission of Chronic Alcoholics to IAS-USC Medical Center - Study and Recommendation, January 1975
- \*Alcohol: The Violent Connection, Newsletter, Calif. Soc. for Treatment of Alcoholism and Other Drug Dependencies, Vol. 2, No. 2, April 1975

16 Newsletter; from the California Society for the Treatment of Alcoholism and Other Drug Dependencies, Vol. 2, No. 2 (April 1975)

17 Id.

18 Secretary of Health, Education, and Welfare, Third Special Report to the U.S. Congress on Alcohol and Health (E. Noble 1978)

19 Interview with Atty Lee Estep, in San Diego, California  
(January 6, 1982)

20 (a) Trial Lawyer; 1973 - 1975; Naval Legal Service Office, Charleston, South Carolina; (b) Staff Judge Advocate (1975 - 1978) (Reviewing cases for error) US Naval Station, San Diego, California. (c) Appellate Attorney, Naval Appellate Review Activity, Appellate Defense Division, Washington Navy Yard, Washington, D.C. (1978 - 1979).

21 Alcoholics Anonymous World Services Inc., Alcoholics Anonymous  
(Third Edition) (1976) at 18.

22 Accepted premise by most physicians who treat alcoholics,  
i.e., Drs. Purvis, Zuska, Pursch, etc.

23 Estimates of percentages of alcoholics as related to the total drinking public vary tremendously. Most authorities estimate, however, that somewhere between 5% and 15% incur some life interference with the use of alcohol.

24 Psalm 104: 15

25 Dr. Gene Purvis - Graduated from the University of Illinois Medical School in 1964. He interned in the U.S. Navy at Pensacola Naval Hospital. He served as a flight surgeon for approximately 3 years before taking his residency in Psychiatry at the National Naval Medical Center, Bethesda, Maryland. He then served as the Marine Corp Recruit Depot psychiatrist in San Diego, California. He was then assigned as the Director of the Naval Alcoholism Rehabilitation Unit at the Naval Regional Medical Center, San Diego, California. After completing 4 years as the Director, he retired from the Navy. He now is in private practice of Psychiatry in San Diego. His practice is almost entirely devoted to treating alcoholics. Dr. Purvis estimates that he treated in excess of 1,000 patients for Alcoholism while in the Navy. He now maintains a patient load of 30 to 40. Prior to going to medical school, Dr. Purvis had been a Marine fighter pilot.

26 Interview with Dr. Purvis in San Diego, California. (January 3, 1982.)

27 Id.

28 AMA, *supra* note 13

29 National Council on Alcoholism/ American Medical Society on Alcoholism, Committee on Definitions, *Annals of Internal Medicine*, Vol. 85, No. 6 (1976) at 1111.

30 APA, *supra* note 10

- 31 American Psychiatric Association, A Psychiatric Glossary (1980).
- 32 World Health Organization, International Classification of Diseases (1977) (Reprint).
- 33 Johnson Institute, Alcoholism; A Treatable Disease (1972).
- 34 Zuska, supra note 15.
- 35 Interview with Dr. Zuska in Orange, California (January 4, 1982).
- 36 Id.
- 37 Id.
- 38 Purvis, supra note 26.
- 39 Id.
- 40 Martin Dodd, et. al., Definition of Alcoholism from the Community Model Viewpoint (1971 - Approximately) (Reprint).
- 41 H. Wallgren, H. Barry III, Actions of Alcohol, Vol. II, Chronic and Clinical Aspects (1970) at p. 716.
- 42 Id.
- 43 Unity and mutual identification are important in the recovery process of the Alcoholic.
- 44 M. Keller and M. McCormick, A Dictionary of Words about Alcohol (Undated).
- 45 First Special Report to the U.S. Congress on Alcohol and Health - Alcohol and Health, (December 1971).
- 46 Purvis, supra note 26.
- 47 Directive issued from the Office of the Chief of Naval Operations; titled OPNAVINST 6330.1 of 29 May 1973 (Enclosure 1).
- 48 OPNAVINST 6330.1 of 29 May 1973 (Basic Instruction).
- 49 Purvis, supra note 26.
- 50 Id.

- 51 J. Kellerman, Alcoholism, A Merry-go-round Named Denial (1980).
- 52 Johnson Institute, The Enabler: The Companion to Chemical Dependency (undated).
- 53 Tough Love - A term used in AA and other therapy concepts in which the person with the disease is allowed to make mistakes and learn from them; the opposite behavior to being an "Enabler." What appears to be uncaring and unhelpful behavior in the "significant others" handling of the Alcoholic is really the most therapeutic mode of activity.
- 54 CDR G.A. Bunn, USN, did his undergraduate work at the University of Washington, in Political Science and the Far East. He also specialized in Languages. He served in ships at sea and in the Intelligence field as well as spending some time in Criminal Investigations. In 1974, CDR Bunn became interested in the Navy's Alcohol Treatment program. He was one of the driving forces in establishing the very successful NASAP program (screening and education) and he is now serving as the Commanding Officer of the Alcoholism Rehabilitation Center at the U.S. Naval Station, San Diego, California.
- 55 Interview with CDR Bunn in San Diego, California (January 7, 1982).
- 56 J.E. Schmidt, Attorney's Dictionary of Medicine and Word Finder (1978) Vol. 1, p. 116, 117.
- 57 392 U.S. 514 (1968).
- 58 Model State Act related to 42 U.S.C. § 2688e, now modified and recodified at 42 U.S.C. § 225a (1981). Act adopted by the National Conference of Commissioners on Uniform State Laws (August 1971).
- 59 346 F. Supp. 17 (1972).
- 60 361 F.2d 50 (1966).
- 61 549 P.2d 1190 (1976).
- 62 339 A.2d 401 (1975).
- 63 101 Idaho 657, 619 P.2d 1110 (1980).
- 64 87 Wn.2d 103, 549 P.2d 721 (1976).
- 65 85 Wn.2d 196, 532 P.2d 621 (1975).
- 66 No. 4, September Term Court of Appeals of Maryland Slip Opinion (1981).



67 Id.

68 613 P.2d 1304 (1980).

69 Id.

70 When I was serving as an appellate defense counsel at the Naval Appellate Review Activity, I was always sensitive to assigning alcohol related issues as error. Even if the specific assignment of error had little chance of success, my brief edified the court regarding the disease.

71 This definition is my own. In deriving it, much valuable analysis was accomplished. The reader is encouraged to come up with his or her own definition. In so doing, the disease process can be conceptualized effectively.

72 Citation and case name are omitted for privacy considerations.

73 Court of Military Review - 1st level appellate court in the military. Each service has its own. Court of Military Appeals - the highest appellate court in the military. There is only one court and it consists of civilian judges.

74 A board of ultimate appeal, limited in its power to recommend clemency or deny it. Not a court of law, membership of the board consists of senior line officers, a physician, and a lawyer.

75 A minimum of 20 years active duty is required to retire with benefits and a monthly retainer.

76 Bunn, supra note 55.

77 Psychiatric term (informal) - Dr. Purvis explains that a double message is transmitted when the person attempting to communicate is defensive and unwilling to share his or her feelings honestly with another person.

78 Interview with Judge Leon Emerson of the Municipal Court of the county of Los Angeles, Downey District, in Downey, California (January 4, 1982). Judge Emerson attended both college and law school at Southwestern University. After nine years of general practice in Downey, California, he was appointed to the bench. He has been sitting as a municipal judge since 1961. Judge Emerson teaches a course at the Utah School of Alcoholism, University of Utah. He lectures extensively on the interface between Alcoholism and the Criminal Justice system. He has appeared on radio and television programs and has made six

motion pictures on the subject of Alcoholism and Criminology. Judge Emerson has been instrumental in forming local Detoxification Centers. He has served on the Alcoholism Commission of Los Angeles County and was Chairman of the Alcohol Abuse Committee of the National Judges Association. Judge Emerson was also instrumental in formulating Alcoholism programs for the California State Bar. This year, he is scheduled to speak before the Texas Bar Association and the Colorado Bar Association.

- 79 National Council on Alcoholism, *supra* note 29.
- 80 Sec. HEW, *supra* note 18.
- 81 Personal observation in several cases.
- 82 Purvis, *supra* note 26.
- 83 Original source unknown - common expression used by some Irish recovering Alcoholics.
- 84 AMA, *supra* note 13.
- 85 Weakness, wasting of leg muscles, motor and sensory impairment. *Id.*
- 86 "acute disorder characterized by ataxia, ocular abnormalities and mental confusion." *Id.* at 63.
- 87 AMA, *supra* note 4.
- 88 AMA, *supra* note 13 at 58.
- 89 Violation of Article 90, Uniform Code of Military Justice, maximum allowable punishment - Dishonorable Discharge, 10 years confinement at hard labor, and total forfeiture of pay. MCM 1969 (Revised) § 127 c.
- 90 Severe confusion, disorientation, severe agitation, fever, tachycardia, restlessness, inability to stay still; very serious - medical emergency. AMA, *supra* note 13 at 60.
- 91 Alcoholic Hallucinosi s - Hallucinations can be visual or auditory. Patient stays aware of reality, but hears or sees things that are not there. *Id.* at 59.
- 92 Rum Fits - Convulsions as in Epilepsy. *Id.* at 58.
- 93 Interview with Dr. Purvis in San Diego, California (August 1976).

94 An alcoholic in Delirium Tremens can be very destructive. He is in an agitated state and is irrational. Physicians and nurses who have treated alcoholics in such a state are always impressed at how strong and destructive the Alcoholic can be.

95 Although Vodka lacks the definitive odor of whiskey or gin, it can be detected on the breath of the drinker. It is especially noticeable at 8:00 am.

96 Alcoholics will go to almost any lengths to insure their ability to get a drink. A now recovering alcoholic of my acquaintance used to store a fifth of liquor in an empty garden hose, so his wife would not find it. Hiding bottles in the storage tank of the toilet is also common.

97 AMA, supra note 13 at 43.

98 Johnson Institute, supra note 33.

99 A recovering alcoholic pilot of my acquaintance told me of his climbing into an airplane in California with a bottle and flying to Texas. He took off, navigated, and landed the airplane several hours later, and did not remember the trip.

100 Graph is for exposition purposes only. The BAC, years of drinking, comfort level, and Blackout levels are assumed figures, not derived from research data. Such data is not available.

101 J. Zuska, Wounds Without Cause, Bulletin, American College of Surgeons, (October 1981).

102 AA, supra note 21 at 31.

103 Id.

104 548 F.2d 239 (1977).

105 448 F. Supp. 1142 (1978).

106 Zuska, supra note 35.

107 In most disease-concept treatment units, therapy is provided for the family of the alcoholic in addition to the alcoholic himself. Al-anon and Al-ateen family groups exist to supply long term treatment for the family members and other "significant others" in the life of the Alcoholic. The focus of the treatment is to help the family members and "significant others," themselves, not necessarily the Alcoholic.

108 Alcoholics Anonymous World Services Inc., As Bill Sees It, (selected writings of AA's co-founder) (1976) at 177.

- 109 purvis, supra note 93.
- 110 Interview with Dr. G. Purvis in San Diego, California (1977).
- 111 AA World Services, supra note 21 at 105 - 106.
- 112 These checklists usually appear in articles written for and published in popular magazines. They are probably helpful, but if the person is in denial, the checklist will be of very little value.
- 113 One such case was my representation of the senior officer I discussed earlier. Another was the case of a lady friend of mine; she has now been sober for 4 years.
- 114 R. Ryback, M. Eckart, C. Paulter, Biochemical and Hematological Correlates of Alcoholism, Research Communications in Chemical Pathology and Pharmacology, Vol. 27, No. 3 (March 1980).
- 115 Judge Beard attended Pasadena Junior College, Redlands University, and received his J.D. from Southwestern University in 1949. He worked in the District Attorney's Office after a short time in private practice. He served four years as the chairman of the Workman's Compensation Board of California. He then returned to private practice and remained in private practice for 30 years, until he was appointed to the bench in El Cajon, California. The El Cajon court is a "unified" court. That is, both felonies and misdemeanors are tried, as well as civil cases. It lacks jurisdiction to try only juveniles and probate matters. Judge Beard has devoted much effort and study to the disease of Alcoholism. He is one of the acknowledged experts in the field.
- 116 Interview with Judge Beard in El Cajon, California (January 5, 1982).
- 117 Emerson, supra note 78.
- 118 Id.
- 119 A term used in connection with "Tough Love;" that is, allow the Alcoholic to experience the natural consequences of his own acts.
- 120 Established under directive - OPNAVINST 6330.1 of 29 May 1973.
- 121 If the cost of drinking can be raised by the suspended sentence, the newly recovering alcoholic may be able to make it through the initial stages of recovery. Such a sentence is often therapeutic.
- 122 OPNAVINST 6330.1 of 29 May 1973.

- 123 Bunn, supra note 55.
- 124 Purvis, supra note 93.
- 125 Id.
- 126 Estimates vary, however, Alcoholics recover very quickly relative to the number of years they drink pathologically. A measure of about 1 month per year of drinking is reported to be about the mean.
- 127 Purvis, supra 93.
- 128 Id.
- 129 Pruvis, supra note 26.
- 130 Purvis, supra note 93.
- 131 A favorite saying of many recovering Alcoholics in AA. Derived from the first word of the first step of Alcoholics Anonymous - See text of paper at 75.
- 132 Zuska, supra note 35.
- 133 Turning point - where the desire to not drink is stronger than the desire to drink.
- 134 Personal observation at the Arlington Hospital Alcoholism Training Unit (ATU), Arlington, Virginia.
- 135 That point in the progression of the disease where the Alcoholic finally sees that the lies don't work anymore and the excuses are not viable. The problem is not the Boss, the wife, or the kids; it is the alcohol.
- 136 AMA, supra notes 92, 94.
- 137 Short term effective tranquilizer used in the treatment of Alcoholism to reduce the severity of withdrawal symptoms and prevent DTs. Extended use is contra-indicated, as Alcoholics tend to be cross addictive. Purvis, supra note 93.
- 138 Similar drug to Librium, but of slightly longer period of effectiveness. Same limitations apply regarding long term use. Purvis, supra note 93.
- 139 Recovering Alcoholic Physician, humorously described his alcoholism in such terms.

140 "... consist(s) of a crisis or crises, which, in an objective, unequivocal, and non-judgemental manner, confront the alcoholic with the reality of his condition." Johnson Institute, Alcoholism: A Treatable Disease (1972).

141 Zuska, supra note 35.

142 CARP - Chemical and Alcohol Rehabilitation Program.

143 ATU - Alcoholism Training Unit.

144 Antabuse comes in pill form. It is administered once per day. After two or three days, it reaches such a concentration in the body that in some patients even alcohol based aftershave lotion causes a mild reaction.

145 Purvis, supra note 93.

146 See supra note 53.

147 Same components exist at Arlington Hospital ATU, Tri-Service Alcoholism Rehabilitation Service at the National Naval Medical Center, Bethesda, and many others.

148 The U.S. Navy's Alcoholism Rehabilitation Dry-Docks are good examples. Much education and group therapy is available, and attendance at AA is stressed, but the program is part-time; or if full-time, it is for a very short period of time. There are no live-in facilities at the dry-docks

149 Such facilities are extremely helpful. In Alexandria, Virginia, alone, there are three such facilities; The Men's Home, The Robinson House, and Stepping Stones.

150 Purvis, supra note 26.

151 J. Zuska, A Physicians Open Letter to Alcoholics Anonymous, California Society for the Treatment of Alcoholism and Other Drug Dependencies, Vol. 8, No. 1 (January 1981).

152 Purvis, supra note 26.

153 J. Zuska and J. Pursch, Long Term Management, Chapter 7 in Alcoholism: A Practical Treatment Guide (1980).

154 The Preamble was written anonymously by the originators of AA. Almost all AA meetings open with the Preamble being read, in full, by the leader.

155 One of the sayings that are very popular with members of AA. Others are "Easy does it," "First things First," and "This Too Shall Pass."

156 Once a recovering alcoholic starts to drink again, he ends up drinking pathologically and must undergo the detoxification procedure again. He may not get to the point of wanting to quit again for an extended period of time. However, eventually, he either quits and starts recovery, again, or dies, goes insane, or ends up incarcerated.

157 Emerson, *supra* note 78.

158 Information available from AA central in both cities.

159 Recently, it was reported that AA is now in 109 countries. AA is spreading rapidly through the western world and some third world countries. It has not apparently been established in the eastern block.

160 One Day at a Time - Refers to the mind-set of the recovering alcoholic. The theory is that anyone can stop drinking for one day, but stopping drinking permanently is almost impossible. Most alcoholics have sworn off forever many times. It does not work. Not drinking today and linking those today's together does work.

161 The same steps are used, except "Alcohol" is supplanted by "Narcotics" or "fattening food" in the first step.

162 "Co-Alcoholic," A "significant other" to the alcoholic and usually an enabler. I first heard the term used by Dr. Purvis in San Diego, California, in 1976. It is widely used today.

163 The recovering alcoholic need not be perfect. He is a human being and is bound to make mistakes. Acceptance of his own humanness is the essence of the Alcoholic's spiritual progress rather than spiritual perfection.

164 Purvis, *supra* note 26.

165 *Id.*

166 AA World Services, Inc., *supra* note 108 at 217.

167 Purvis, *supra* note 93.

168 Purvis, *supra* note 26.

169 Zuska and Pursch, *supra* note 153.

- 170 Purvis, *supra* note 26.
- 171 Emerson, *supra* note 78.
- 172 Blue Cross and Blue Shield has now disallowed treatment for alcoholism from its standard group coverage.
- 173 G. Burn, P. Bromley, NASAP; A Family of Winners (1980).
- 174 Even though AA is not a funded referral service, helping an alcoholic get sober is fundamental to the program (12th step). Therefore, the recovering alcoholic who is covering the central desk will always be most helpful.
- 175 J. Mosher et. al., ALCOHOL: Both Blame and Excuse for Criminal Behavior (January 1981) (unpublished manuscript - prepared for presentation at conference on Alcohol and Disinhibition - February 1981; University of California at Berkeley).
- 176 MCM 1969 (Revised) 216 h.
- 177 *Id.*
- 178 Since "Damaging Government Property" is a general intent offense vice a specific intent offense, voluntary intoxication would not amount to a defense.
- 179 An individual might have potential to be an alcoholic but, certainly, without ever introducing the chemical into his body to start the reaction, he cannot be called an Alcoholic.
- 180 Mosher, *supra* note 175.
- 181 Recommended procedure under OPNAVINST 6330.1 of 29 May 1973.
- 182 In the eastern United States, colored poker chips are awarded for periods of sobriety in AA; white for 0-30 days, blue for 30-90 days, red for 90-180 days, yellow for 6 months to 9 months, and green for 9 months to one year. For one year and subsequent years, metal chips are awarded.
- 183 The Military Judge (then LCDR) James N. Rogers showed excellent insight and a fine sense of sentence appropriateness in this difficult case dealing with Alcoholism in a mature petty officer.



184 Attorney Lee Estep of San Diego, California, graduated from the University of Arizona Law School in 1959 with an LL.B. He went on to study for, and receive, his doctorate. He is retired from the U.S. Marine Corp for disability, having been wounded during the Korean conflict. In his first 14 years of practice, he handled primarily criminal cases. Mr. Estep defended 27 capital cases, prior to the time California did away with capital punishment. In more recent years, Mr. Estep has broadened his practice to include general litigation work, family law and real estate. He has worked hard to establish the San Diego Crisis committee to help fellow lawyers who develop alcohol problems. He was given an award by the San Diego Bar Committee for his assistance in establishing the committee. Mr. Estep does a great deal of Pro-bono work with recovering alcoholics in the area. He is recognized by his peers as being a very able attorney and counselor and as having a great deal of knowledge concerning the disease of Alcoholism.

185 Interview with Attorney Lee Estep in San Diego, California (January 6, 1982).

186 An AA sponsor is a person with whom a new member forms a special relationship. The new member receives guidance and assistance from his or her sponsor.

187 Without the survival and recovery plan, Mr. Carroll would tend not to recommend probation.

188 Father Martin is a Roman Catholic Priest who is a widely recognized lecturer on Alcoholism. He has filmed several lectures for the U.S. Navy. Among these motion pictures, are Chalk Talk, Guidelines, and the Family.

189 Purvis, supra note 26.

190 R. Gerstle and S. Bucky, Report No. 78-2, Alcoholism Treatment Effectiveness for Naval Officers, as partially reprinted in M. Hanrahan, Voluntary v. Involuntary Treatment of Alcoholics. The Florida Bar Journal (April 1982).

191 Id. at 313.

192 M. Hanrahan, Voluntary v. Involuntary Treatment of Alcoholics, The Florida Bar Journal (April 1982) at 313.

193 Judges Emerson and Beard agree, and many others are following suit.

194 Hanrahan, supra note 192 at 314.

195 42 U.S.C. § 2688e omitted by P. 97-35 Aug 13, 1981, 95 Stat 560 - Omnibus Budget Reconciliation Act of 1981 (Statutory Authority continued in modified form, 42 U.S.C. § 225a (1981)).

196 Official cite unavailable, Law passed by legislature and given royal assent, but not acclaimed. AA Grapevine (January 1982) at 43.

197 Emerson, *supra* note 78.

198 *Id.*

199 *Id.*

200 *Id.*

201 *Id.*

202 Beard, *supra* note 115.

203 Beard, *supra* note 116.

204 *Id.*

205 *Id.*

206 Conference titled, "Carrying the Message to Alcoholics in Prison" (February 21, 1982) Burke, Virginia.

207 Purvis, *supra* note 110.

208 Emerson, *supra* note 78.

209 Purvis, *supra* note 26.

210 *Id.*

211 Alcoholics Anonymous World Services Inc., A.A. in Prisons (1979); Alcoholics Anonymous World Services, Inc., Memo to an Inmate who may be an Alcoholic (1961).

212 AA Grapevine Inc., A Greater Freedom (July 1981).

213 Conference on "Carrying the Message ..." *supra* note 206.

214 Emerson, *supra* note 78.

215 Purvis, *supra* note 93.

216 John Donne, Meditation XVII (1573 - 1631).

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